CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

BRADLEY E. CHIPPS, M.D.,
F.A.A.P., F.A.C.A.A.I., F.A.A.A.A.I., F.C.C.P.
Pulmonary & Allergic Diseases
Board Certification:
Pediatrics
Pediatric Pulmonology
Allergy and Clinical Immunology

Medical Director, Cystic Fibrosis Center
Assoc. Medical Director Sleep Laboratory
Medical Director of Respiratory Therapy
Sutter Community Hospitals

NEIL G. PARIKH, M.D.
Clinical Immunology, Allergy, & Research
Board Certification:
Internal Medicine
Allergy and Clinical Immunology

SHEENA K. MAHARAJ, M.D.
Pediatric Pulmonology
Board Certification:
Pediatrics
Pediatric Pulmonology (Board Eligible)

Hannah Choi-Baral, C.P.N.P
Pediatric Nurse Practitioner

Christine Anderson, F.N.P-C
Family Nurse Practitioner

Patient Authorization to Release Records to Capital Allergy

Patient Name: _____
Patient DOB: _____

I hereby authorize_____
(Physician or Hospital)

_____
Address

_____ _____ _____ _____
City State Zip Phone

Check the box and initial which type of information is to be disclosed.

- o History and Physical Dates _____
- o Spirometry/PFT Dates _____
- o X-Ray/CT Scan Dates _____
- o Lab Results Dates _____
- o Discharge Summary Dates _____
- o ER Report Dates _____
- o Skin Tests Dates _____
- o Antigen Formula Dates _____
- o Shot Record Dates _____
- o Sleep Study Dates _____

Specify the records to be disclosed:

_____

Please disclose the following protected health information to:

5609 J Street Suite C
Sacramento, CA 95819
Fax: 916-453-8715

I understand that I have the ability to revoke this authorization providing CARDC with a written revocation unless CARDC has already disclosed the records to recipient relying upon this authorization. A written revocation should be sent to Capital Allergy at 5609 J Street, Suite C, Sacramento, CA 95819.
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.I further understand that CARDC will not condition its provision of treatment to me upon my execution of this Authorization and that my participation is completely voluntary unless any treatment relation to research or healthcare services are provided to me for the purpose of creating protected health care information to disclose to a third party. I understand that I have the ability to inspect or copy my medical records that will be disclosed to the recipient above.

_____
Signature: Patient or Personal Representative **Date**

_____
Authority for Personal Representative **Date**