ALLERGY & ASTHMA
CONSULTANTS OF MONTANA

MICHAEL C. DICELLO, MD
CINDY K. FEDDES, FNP

REQUEST FOR TRANSFER OF RECORDS

Patient legal name: _____

DOB: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize: **Allergy & Asthma Consultants of Montana**
Dr. Michael C. DiCello / Cindy K. Feddes, FNP
1188 North 15th Avenue, Suite 3
Bozeman, MT 59715
P: 406.582.1111 F:406.582.1112

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

Person/Name of Organization or Provider:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Reason:

- ☐ Patient Request
- ☐ Other:_____

Records Needed:

- ☐ Entire Record (may have additional cost)
- ☐ Dates of treatment needed: _____
- ☐ Specific item(s) needs: _____

This authorization is subject to revocation at any time by giving written notice to Allergy & Asthma Consultants of Montana. The revocation is effective from the time it is received by Allergy & Asthma Consultants of Montana and does not apply to actions prior to receipt. If not revoked, this authorization terminates twelve (12) months from the date of its execution.

I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that this request acts only as a single time use and my information will only be released to the above-named recipient. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be re-disclosed.

I authorize (name/relationship):_____ to pick up my records in my absence.

PATIENT SIGNATURE_____ **DATE**_____
(GUARDIAN SIGNATURE IF PATIENT IS UNDER 18)

PRINTED NAME OF SIGNER _____