ALLERGY & ASTHMA
CONSULTANTS OF MONTANA

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

MEDICAL RECORDS RELEASE

Patient legal name: _____

DOB: _____ Phone Number: _____

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

I authorize:

Medical Practice / Provider Name: _____

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

Phone: _____ Fax: _____

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

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

Records Needed:

- ☐ Laboratory Data: _____
- ☐ X-Ray / Radiology Reports: _____
- ☐ Skin Testing: _____
- ☐ Allergen immunotherapy extract composition: _____
- ☐ General Treatment Records: _____
- ☐ Other: _____

By signing this authorization I request 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 will be in effect for one year from the date signed and my information will only be released to the above-named recipient.

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

PRINTED NAME OF SIGNER _____