



Mark E. Bubak, M.D. &  
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**605-336-6385**  
*YourAllergyRelief.com*

## RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Hospitalization/ Appointment Date: \_\_\_\_\_

***I hereby authorize*** to release information from the medical record as follows:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergy testing           | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Report(s) |
| <input type="checkbox"/> Allergy consultation      | <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> ENT consultation          | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Entire Record       |
| <input type="checkbox"/> Sinus CT                  | <input type="checkbox"/> X-ray Reports        | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Immunotherapy Formulation |   | _____  |

I specifically request that the above information be released to:

Dakota Allergy & Asthma  
2200 West 49th St. , Sioux Falls, SD 57105

- for the purpose of:
- Continued Health Care
- Completion/Payment of Hospital Insurance Claim
- Other

I understand that the information to be released may include information regarding drug abuse and/or alcoholism or alcohol abuse.

This authorization shall be in effect for one year from this date, unless revoked by me in writing at any time, except to the extent that action has already been taken to comply with it.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date: \_\_\_\_\_ Information Sent: \_\_\_\_\_