A division of:
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(618) 250-4688 / Fax (618) 624-2226 / www.quellheadache.com / info@quellheadache.com

Quell/AAIC Record Release Authorization

This form provides authorization to the Allergy, Asthma & Immunology Center, SC (AAIC) dba Quell Headache Wellness Centers (Quell) to use or disclose your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. Please read and complete this form in its entirety and return to us.

Patient Name: _____ **DOB**: _____ **AAIC #**:_____

I hereby authorize AAIC, SC and Quell to release to/obtain from (circle one):

Name: _____
Address: _____
City, State, Zip Code: _____

The following information should be released (please specify dates of service, specific information to be released, etc.)
_____
_____
_____

The purpose for the information being released is:
___Specialist Referral ___Second Opinion ___Transfer of care

Other (please specify): _____

This authorization is good for a period of one year from the date signed. I understand that I have the right to revoke this authorization at any time, in writing. I understand that a revocation is not effective to the extent that AAIC, SC has taken action in reliance on this authorization. I understand there is the potential for information released pursuant to this authorization to be re-disclosed by the recipient if the recipient is not required by law to protect the privacy of information.

Signature of Patient or Personal Representative: _____

Date: _____

Description of Personal Representative's authority: _____

Revised 3/3/2023