San Francisco
Allergy | Asthma | Immunology
OPAL K. GUPTA, MD
JEFFREY M. DAVIDSON, MD
SYLWIA NOWAK, MD
SOWMYA ARJA, MD

Transferring Allergy Shots to Our Office

Thank you for your interest in transitioning your allergy shot care to our practice.

For allergy shots to be transferred to our office, we require that you have previous records sent to us for review AND that you have a video visit consultation with one of our doctors. These steps must be completed in order to determine if we are able to accept your allergen vials from your current allergist.

Step 1: Please have your current allergist send us the following records:

- Allergy skin prick test results and/or bloodwork results for allergies
- If you have asthma, any respiratory testing (breathing tests, chest x-rays, etc.)
- Allergy shot vial contents (including dosing, manufacturers and concentrations)
- Most recent allergy shot injection records and current injection schedule/protocols
- Most recent visit notes from provider

To facilitate the transfer of information you may provide the attached release of information form to your current doctor and request the records be faxed to our office at 415.362.2615.

Step 2: Once we have received all of the above items, you will be able to schedule an appointment with one of our providers. You can call at 415.362.2614 to schedule a video appointment. Please let us know if you have a preferred site at which you would like to receive your injections and we can match you with a doctor.
Shot locations and hours are located on our website at *https://www.sf-allergy.com/shot-clinic/*

Please note: We will not accept outside vials prior to your video consultation with our provider. During this visit your individualized immunotherapy treatment plan will be discussed, including possible adjustments to therapy. Please do not have vials sent to our office until officially accepted by our provider. If it is determined that we will be using your vials from your current provider, we will help facilitate the transfer.

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Authorization for Release of Medical Records

Patient Name: ______________________________________ Date of Birth: ___________________

I hereby authorize ______________________________ to disclose the following information to San Francisco Allergy, Asthma & Immunology.

Covering the period(s) of healthcare: From: __________________ To: __________________

Information to be disclosed:

- ☑ Complete Health Records(s)
- ☑ Allergy Skin Test Result(s)
- ☑ Laboratory Report(s)
- ☑ Allergy Subcutaneous Immunotherapy Treatment Record(s)
- ☑ Allergen Subcutaneous Immunotherapy Contents
- ☑ Pulmonary Function Testing
- ☐ Imaging
- ☑ Office notes
- ☐ Other (please specify):
  ____
  ____
  ____

This information will be disclosed to San Francisco Otolaryngology Medical Group.

Please mail or fax to:

SFAAI
450 SUTTER ST. SUITE 933
SAN FRANCISCO, CA 94108
PHONE (415) 362-2614 FAX (415) 362-2615

Please transfer requested information by this date: ___________________________________

I understand this authorization may be revoked in writing in at any time, except to the extent that action has been taken in in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

____ ______________________
Patient or Parent/Guardian Signature Date