Asthma and Allergy Center
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) Patient Information: ____
Name of Patient / Previous Name

___________________________ (________)____________________________
Date of Birth Area Code / Telephone Number

____
Address City/State/Zip

2) Persons/Organizations Authorized to Disclose Patient's Health Information:

____
Name of Health Care Provider / Plan / Other

____
Street Address

____
City/ State/ Zip

3) Persons/Organizations Authorized to Receive Patient's Health Information: [ ] Self; or

____
Name of Health Care Provider / Plan / Other

____
Street Address

____
City/ State/ Zip

4) Delivery Options: [ ] Mail [ ] View of Site [ ] Fax: ______________________________
[ ] Hand Carry/Pick-Up (Date & Time) ____________________________________
[ ] Authorized Person to Pick-Up Health Information___________________________

5) Health Information to be disclosed: *(Check applicable information)* [ ] Office Notes
____ [ ] Laboratory
Reports (Specify Test) ____ [ ] Billing
Records____
[ ] Other____
For the following date(s)____

I do not want the following health information disclosed: *(Check applicable information)*
[ ] Human Immunodeficiency Virus (HIV) Test Results [ ] Developmental Disability Records
[ ] Mental Health Records [ ] Alcohol and Drug Abuse Records

6) Purpose for Need of Disclosure: *(Check applicable categories)*
[ ] Further Medical Care [ ] Legal Investigations [ ] At the Request of the Individual
[ ] Insurance Eligibility/Benefits [ ] Other: ____________________________________

7) Expiration Date: This Authorization is good until the following date(s) / event______________________
If not date or event is specified, this Authorization will expire one (1) year from the date signed.

Prohibition on Re-Disclosure: This information is protected by Federal and state confidentiality laws. Such laws prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by such laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I have had an opportunity to review and understand the content of the Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

8) Signature of Patient/ Legal Rep: ______________________________ Date: ____________________
Relationship or Authority to Act for the Patient____
(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child because such placement would endanger the child's physical, mental, or emotional health.)

For Office Use Only: Records Picked Up by: ____________________________ Date:____________________