The Asthma & Allergy Center

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# Patient Authorization for Use and Disclosure of Protected Health Information from The Asthma & Allergy Center

**Please complete and send to The Asthma & Allergy Center so we may forward your records to another facility.**

Patient Name: _____ Date of Birth_____

I authorize **The Asthma & Allergy Center, P.C.** to disclose certain protected health information (PHI) about me to:

_____
Name of Physician/Medical Facility

_____
Address

_____
City/State/Zip

The extent of information to be disclosed includes the following:

_____Specified Information: _____ Last 2 years of medical records
_____Skin Tests
_____Extract Rx
_____Lab
_____Other: _____

The information will be used or disclosed for the following purpose (s):

_____review or examination of records by another physician
_____at the request of the individual
_____Other:_____

This authorization will expire in 90 days unless otherwise noted: _____.

Payment will ___ will not ___ be received from a third party in exchange for using or disclosing the PHI.

- *I do not have to sign this authorization in order to receive treatment from The Asthma & Allergy Center.*
- *I have the right to refuse to sign this authorization.*
- *Once this information is released to the individual/facility listed above, The Asthma & Allergy Center has no control over the recipient's use and the information may no longer be protected by the federal HIPAA Privacy Rule.*
- *I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at The Asthma & Allergy Center.*

_____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date

_____ _____
Print Name of Patient or Legal Guardian Chart #

***PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION***

*Reserved for AAC: S://Office Forms/HIPAA Forms*