The Asthma & Allergy Center

3503 Samson Way #108 • Bellevue, NE 68123-4303 PHONE (402) 592-2055 FAX (402) 592-2419 www.asthmaandallergycenter.com

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth_____

I authorize: _____
Name of Physician/Medical Facility

_____
Address City/State/Zip

_____
Phone Fax

To disclose a copy of the specified protected health information for continuity of care about me to:

The Asthma & Allergy Center, P.C.
3503 Samson Way, Suite 108 Phone (402) 592-2055
Bellevue, NE 68123-4303 Fax (402) 592-2419

Provider: _____

If your medical records from another allergist, pulmonologist, dermatologist or gastroenterologist would be pertinent to your office visit with us, please complete this form and mail to that specialist. The information to be disclosed includes:

_____ Last Office Note _____ Skin Tests _____ Labs

_____ PFT or Spirometry _____Allergy Shot Rx _____ CT/imaging reports (i.e. sinus, head, chest)

_____ Biopsy report (i.e. skin or endoscopy)

_____Other: _____

The information will be used or disclosed for the following purpose (s):
XXX 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.*
- *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
Scanned copy of Signature considered as original

_____ _____
Print Name of Patient or Legal Guardian Chart #

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