ALLERGY CONSULTANTS

Adult and Pediatric Allergy

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Authorization for Use of Protected Health Information

(Medical Records Release)

Patient Name ____ **Soc. Sec. #**: ______________

Date of Birth: ________________________________ Patient Account #: ________________________

1. I authorize Allergy Consultants to use and/or disclose my protected health information specific to the following date or time period: ____

2. **Individual or entity authorized to receive my protected health information**:
(please include complete address and/or fax number)
____

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3. **Purpose for which disclosure is to be made**:
____

4. By initialing the spaces below, I specifically authorize the use and/or disclosure of the following protected health information and/or medical records, if such information and/or records exist:

___ Please send the entire medical record (all information) to the above named recipient or only send:

___ Office chart notes

___ Laboratory reports

___ Skin test results

___ CT/Xray reports

___ Billing statements

___ Allergen Extract formula

___ Medical records needed for continuity of care

___ Pulmonary function results

___ Emergency and urgent care records

___ Other: ___________________________

___ Please send any secondary medical records (any records from another physician/entity sent to Allergy Consultants.)

5. I understand that if the person(s) or entity(ies) that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Allergy Consultants, its employees, and my physicians from all liability arising from this further disclosure of my health information.

6. I understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

7. I understand that I may inspect or request copies of any information disclosed by this Authorization. It is my understanding that this Authorization will expire in 90 days from the date signed below. I understand that I may revoke this Authorization by notifying, in writing, Allergy Consultant's Privacy Officer, knowing that previously disclosed information would not be subject to my revocation request.

8. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

____ ______________
Signature; Patient or Legal Representative Date

____
Print Patient's Name

____ ______________
Signature of Witness Date 10/2003