ALLERGY CONSULTANTS

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Authorization for Use of Protected Health Information (Medical Records Release)

Patient Name: _____ Date of Birth: _____

1. I authorize Allergy Consultants to use and/or disclose my protected health information for the following date or time period: all time_____ specific dates: _____
2. Individual or entity authorized to receive my protected health information (include name, address, and fax # if needed):
   _____ Method of getting protected health
   _____ information to named:
   _____ Fax ____ Mail____ Pick up____
   _____
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 name recipient or only send:
   _____ Office chart notes _____Allergen Extract formula
   _____ Laboratory reports _____Emergency and urgent care records
   _____Skin test results _____Billing statements
   _____CT/Xray reports _____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 receive(s) 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 Consultants, 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