



Lisa V. Suffian, M.D., FAAAAI  
Gary M. Goodman, M.D., FAAAAI  
Alexia Munter, FNP-BC  
Jessica Thomure, NP

456 N. New Ballas Road, Suite 129  
St. Louis, Missouri 63141  
(314)569-1881  
FAX: (314)569-3277

### 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