ALLERGY & ASTHMA INSTITUTE

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AUTHORIZATION/ CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Patient Address: _____

Please check one of the following:

- ○ Please release all records *from* Allergy & Asthma Institute *to* our new Physician, _____.
- ○ Please send records to Allergy & Asthma Institute.

By signing below, I hereby authorize Allergy & Asthma Institute to use or disclose information about myself (or another person for whom I have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Please Release:

____ Entire Medical Record
____ Records from dates _____ to _____
____ Other (specify) _____

Release Records To:

____ Physician's Office
____ Other (specify) _____

Records are to be released to the following:

Name: _____
Address: _____
Phone: _____
Fax: _____

Reason for Request:

____ Moving
____ Changing Physicians
____ School/ Daycare
____ Insurance Purposes
____ Referral
____ Requested by Court

This information about your child is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent that we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

_____ _____

Authorized Signature of Parent/ Guardian Date