ALLERGY ASTHMA & IMMUNOLOGY SPECIALISTS

Authorization for Release of Protected Health Information

Name and contact information of the person whose health information is to be released:

Patient Name	Date of Birth	SSN	Contact Phone Number
Address	City	State	Zip

Name of physician, medical office, or hospital authorized to release your health information to Allergy Asthma & Immunology Specialists (EAAA): _____

If EAAA is releasing your health information, please provide the name and information of the person or class of persons to whom EAAA may release the health information:

Name (physician, hospital, insurance company, etc.)	Phone Number	FAX Number

Address	City	State	Zip

Reason for the release: _____

Date by which information is needed: _____

A description of the health information to be released (physician notes, x-rays, procedure records, account information, etc.): _____

The information released could potentially be released again by the person receiving it. You have the right to revoke your permission to release information at any time. If you do so, it does not affect the information that has already been released. If you give permission for another facility or person, other than EAAA, to release your health information and you wish to take your permission away, you must contact that facility or person to withdraw your permission. If you are requesting EAAA to release your health information and you wish to take your permission away, a written notice, which has been signed and dated by the patient whose health information was to be released, should be sent to EAAA at the address listed above with attention to EAAA Administration. The notice should have the following information on it: (1) the patient's name; (2) a description of the health information that EAAA had permission to release; (3) the name or other specific identification of the person(s), or class of persons, that EAAA was going to send the information to; and (4) the date that the permission was signed. EAAA will not refuse to treat you if you do not sign this form.

I have carefully read and understand the above and do herein expressly and voluntarily authorize the disclosure of the above information or medical records of my condition(s) to those persons or agencies listed above.

Signature of Patient or Personal Representative *Form must be completed before signing*	**Date**

Description of Personal Representative's Authority	Witness	Date