Allergy/Immunology Associates, Inc.

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Allergy/Immunology Associates, Inc. to use and/or disclose my protected health information as described below to

(Name and address of recipient)_____

_____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

_____

_____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Allergy/Immunology Associates, Inc. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the ri ght to contest a claim under the policy.
4) Allergy/Immunology Associates, Inc. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:
☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record
☐ Office Chart Notes
☐ Billing Statements
☐ Dental Records
☐ Laboratory Reports
☐ Pathology Reports
☐ Consultation
☐ Discharge Summary
☐ Most Recent 5 Year History
☐ All Hospital Records
☐ Transcribed Hospital Reports
☐ History and Physical Exam
☐ Emergency and Urgent Care Records
☐ Medical Records for Continuity of Care
☐ Diagnostic Imaging Reports
☐ Emergency Room Reports
☐ Radiology Reports
☐ Operative Reports
☐ Other _____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Expiration:
This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____ **Patient ID #:** _____

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____ _____
Signature of Witness **Date**

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