Allergy and Asthma Specialists, Ltd.

STANDARD AUTHORIZATION OF USE AND RELEASE OF PROTECTED HEALTH INFORMATION

INFORMATION TO BE USED OR RELEASED

[ ] Medical
[ ] Financial

PERSONS AUTHORIZED TO USE OR RELEASE INFORMATION

Allergy and Asthma Specialists, Ltd.

PERSONS TO WHOM INFORMATION MAY BE RELEASED AND RELATIONSHIP (This does not apply to physicians)

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

I give permission to leave test/lab results on my answering machine/voicemail. [ ] YES
[ ] NO

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through __/__/__ unless revoked or terminated by the patient or the patient's personal representative.
[ ] Indefinite

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Allergy and Asthma Specialists, Ltd. Attention privacy officer.

POTENTIAL FOR RELEASE

Information that is disclosed under this authorization may be released again by the person or organization to which it is sent. The privacy of this Information may not be protected under federal privacy regulation.

SIGNATURE

Name of Patient (Print): _____Date of Birth_____

Signature of patient: _____ Date_____

Signature of patient representative:_____ Date_____

Relationship of representative to patient: _____