Allergy & Asthma Specialty Center

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORATION (PHI)

Patient Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

I authorize the release of my medical records from:

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

Please release requested medical records to:

ALLERGY AND ASTHMA SPECIALTY CENTER
1101 W. MAIN STREET, SUITE P
LEAGUE CITY, TX 77573
PHONE: 281-332-6090 FAX: 832-905-6176

I specifically authorize the use and disclosure of the following:

___ Radiology Reports ___ Lab Reports ___ Clinic Notes ___ Allergy Shot Records ___Other: _____

Unless you initial here, no information about alcohol abuse/substance abuse, HIV/AIDS or mental health will be disclosed. _____ **Yes**, disclose my information ____ **No**, do not disclose my information

1.) I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.
2.) I may revoke this authorization by notifying **Allergy and Asthma Specialty Center** in writing my desire to revoke it. However, I do understand any action already taken in reliance on this authorization can not be reversed, and my revocation will not affect those actions.
3.) My purpose/use of this information is for _____.
4.) This authorization expires **90 days after it is signed**.

- THIS FORM MUST BE FULLY COMPLETED PRIOR TO BEING SIGNED. -

Signature Date