AUTHORIZATION FOR DISCLOSURE
OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip _____

AUTHORIZES:

Asthma & Allergy Associates
4601 W. 6th Street
Lawrence, KS 66049
Fax: 785-842-4219
Dr. Ronald Weiner
Dr. Warren Frick

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Fax Number

INFORMATION TO BE RELEASED:

□ Medical History, Examination, Reports
□ Treatment or Tests
□ Allergy Records
□ Consultations
□ Surgical Reports
□ Hospital Records Including Reports
□ Laboratory Reports
□ Entire Record
□ Immunizations
□ X-ray Reports
□ Prescriptions
□ Other (Specify): _____

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

□ Further Medical Care
□ Insurance Eligibility/Benefits
□ Legal Investigation or Action
□ Changing Physicians
□ Personal
□ Other (Specify): _____

I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting us in writing as listed above. **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, please contact us at the address listed above. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed. I have had an opportunity to review and understand the content of this authorization for. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE**: _____
(If signed by other than patient, state relationship and authority to do so.)

WITNESS: _____