AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip _____

AUTHORIZES:

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Asthma & Allergy Associates P.A.
4601 W. 6th Street
Lawrence, KS 66049
Phone: (785) 842-3778 Fax: (785)842-4219

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: _____