HIPAA Authorization to Obtain Patient Records

Date_____ This authorization expires: Date_____(if no date inserted, this authorization expires 1 yr after the date signed)

Patient Information

_____ _____ _____ _____
Last Name First Name MI Date of Birth

_____
Address

_____
Phone Number

I hereby authorize _____to release the following records to Allentown Asthma & Allergy, 1605 N Cedar Crest Blvd, Allentown, PA 18104, Fax: 610-820-9078, Phone: 610-820-9000 (check relevant boxes):

_____ My entire medical record ***OR***
_____ records relating to the following condition only_____
_____ office notes
_____ lab reports/skin tests/pfts
_____ other records

UNLESS MY INITIALS APPEAR BELOW, I specifically and voluntarily authorize _____to include in the release of records any information relating to the following issues, if applicable. My initials indicate I **do not** consent to the release of records relating to the following:

_____ mental health illness/diagnosis
_____ alcohol/drug abuse/treatment
_____ HIV/AIDS test results/diagnosis
_____ communicable diseases

Organization from which the information is being obtained

_____
Organization Name

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Fax

The purpose of the release of my medical records is (patient may decline to specify purpose):

_____

*I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
*I understand that there may be medical records from another doctor or another medical facility in my chart.
*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
*I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.*I have read and understood this authorization, and hereby release Allentown Asthma & Allergy from any and all legal liability arising from the release of records authorized by this authorization, or from any re-disclosure of the records.

_____ _____
Signature of Patient/Parent or Legal Guardian Date