HIPAA Authorization for Release of 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 Allentown Asthma & Allergy to release the following records (check relevant boxes):

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

UNLESS MY INITIALS APPEAR BELOW, I specificall and voluntarily authorize Allentown Asthma & Allergy 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

Person or organization to whom the information is being released

_____ _____

Name Organization

_____ _____ _____ _____

Address City State Zip Code

_____ _____

Phone Fax

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

_____

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*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

Please allow 7 days for transfer of records.