THE ALLERGY & ASTHMA CENTER, P.C
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: ______________________ Patient's Date of Birth: __________________
Address of Patient: _____________________________________
____

I authorize and direct The Allergy & Asthma Center, P.C. ("AAC") to disclose to the following individuals:

Name:	Relationship:	Date of Birth:
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

the following protected health information pertaining to the individual identified above:

___ any and all protected health information in AAC's possession or to which AAC has access relating to the individual's physical and medical condition, treatment, evaluations and otherwise
___ any and all mental health records
___ any and all psychotherapy notes
___ any and all communicable disease records
___ any and all alcohol and drug abuse records
___ other (identify the information in a specific and meaningful fashion_____________________
____

The disclosures authorized herein are made at the request of the undersigned, and I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under the federal privacy rules. This authorization will expire on the date the individual identified above ceases to be an active patient of AAC's practice. However, I understand that I have the right to revoke this authorization at any time, provided that I do so in writing (to AAC) and except to the extent AAC has already disclosed information in reliance upon this authorization.

I acknowledge that I have read and understand the above and agree that this authorization was completed prior to my signature. I further agree that a copy of this authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by AAC.

Date:________________ Signature of Patient:_____________________________________

Minor Patients:

If patient is unable to give authorization because of age, physical condition or otherwise, complete the following: Patient is a minor, ___________years of age,
Or ____,
State relationship to patient____

The undersigned herby certifies and attests that he or she is the duly authorized representative of the individual and has lawful authority to enter into this authorization on behalf of the individual.

Date:___________ Signature of Representative/Legal Guardian_________________________________
Printed Name of Representative/Legal Guardian______________________________

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