Patient Authorization

PATIENT AUTHORIZATION FOR CLINIC TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTY/PARTIES

By signing this authorization, I authorize Allergy & Asthma Specialists, P.A. to use and or disclose certain protected health information (PHI) about me to the party or parties below.

This authorization permits Allergy & Asthma Specialists, P.A. to use or disclose to:

_____
Person or Entity to receive the information Relationship

_____
Address

_____

the following protected health information (specifically describe the health information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____
_____
_____

The purpose of this Authorization is to facilitate:

_____

This authorization will expire one year from the date of my signature or earlier if revoked. I understand that I may revoke this authorization by sending a written request for revocation to the **Clinic's Privacy Officer.** If I revoke this authorization, the **Clinic** will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when the **Clinic** discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I have the right to revoke this authorization in writing except to the extent that Allergy & Asthma Specialists, P.A. has acted in reliance upon this authorization.

My written revocation must be submitted to Allergy & Asthma Specialists, P.A's Privacy Officer, 825 Nicollet Mall, Suite 1149, Minneapolis, MN 55402

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of Patient – Parent – Other Date