ALLERGY & ASTHMA
SPECIALISTS, P.A.

Patient Authorization for Proxy

Patient Authorization for Practice to Release Protected Health Information to Third 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 or for the party or parties listed below.

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

_____

Person or Entity to receive the information

_____

_____

Address

The following individually identifiable health information (specifically describe the 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 on _____

Expiration Date or Defined Event

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. 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

Patient Authorization for Use-Disclosure Form 041003