AIR Care
Allergy, Immunology & Respiratory Care

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

_____	_____
Name of Patient / Previous Names	Birth Date / Social Security Number
_____	_____
Street Address	City, State, Zip

AUTHORIZES MY CURRENT PHYSICIAN :	**TO RELEASE PROTECTED HEALTH INFORMATION TO:**
_____	_____
Physician Name	Physician Name / Self
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip	City , State, Zip
_____	_____
Physician Office Phone and Fax number	Physician Office/Self Phone and Fax number

INFORMATION TO BE RELEASED:

I hereby authorize you to release <u>all</u> of my medical records for any treatment and laboratory/diagnostic test performed <u>except for information pertaining to:</u>

___ Sexually transmitted disease

___ Testing or treatment of HIV/AIDS

___ Treatment of alcohol or substance abuse

___ Communication between patient and psychotherapist for mental health treatment

___ Records from other facilities/providers

For the Following Date(s):_____

PURPOSES FOR NEED OF DISCLOSURE: (Check one)

___ Further Medical Care

___ Insurance / Eligibility

___ Other (Specify):_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand the Air Care Allergy Immunology & Repertory Care PA will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Air Care Allergy Immunology & Repertory Care PA will not refuse to continue treatment. By signing this person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed with obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

PATIENT SIGNATURE / LEGAL REPRESENTATIVE:_____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so)

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six month from the date signed.

Distribution of Copies: Original to provider; copy to patient; copy to accompany released records.