AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use of information from the medical record of:

Patient Name: _____ DOB: _____

I authorize the following individual or organization to disclose the above named individual's health information: _____
Address: _____
Phone: _____ Fax: _____

To: Richard A. Page, M.D.
Family Allergy Clinic
2380 Firewheel Parkway, Suite 1100
Garland, TX 75040
Phone: 972-271-6811/ Fax: 877-573-5077

Please release the following: (Note: List not required by HIPAA)

_____ Progress Notes _____ Allergy Test
_____History/Physical Exam _____ Serum Recipe
_____Medical List _____ Shot History
_____ List of Allergies _____ Spirometry Reports
_____ Demographic/Insurance _____ Lab Reports
_____ Complete Medical Records
Other: _____

For the purpose of: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ YES, I consent to the release of this information.
_____ NO, I do not consent to the release of this information.

I understand that the information release is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, a provided in CFR 166.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact Family Allergy Clinic's Privacy Officer.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Witness: _____