ALLERGY, ASTHMA & SINUS CENTER P.C.

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Authorization Form
For Release of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to the above Acknowledgement Form. The patient may desire other individuals such as family members to have access to their PHI. Use the spaces below to specify those individuals, their relationship to you and any limitations (if any) on the extent of their access to your PHI (ex: billing issues only) and any expiration date to that access. Please list parent(s) name(s) if patient is minor.

Name	Relationship	Limitations/Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further authorize the physicians and their staff to dispense results of my medical exams and all other general information in one or more of the following ways:

□ Home Phone & Voice Mail: ( ) _____

□ Cell Phone & Voice Mail: ( ) _____

□ Work Phone & Voice Mail: ( ) _____

The above-mentioned PHI may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. By signing this form, you authorize the practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke or change this authorization at any time in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the practice.

_____	_____	_____
Printed Patient Name	Patient/Guardian Signature (relation)	Date