

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Allergy & Asthma Centre and its entities, its officers or agents to permit inspection, copying and / or release of health information compiled in the ordinary course of business in connection with the following:

Patient Name: _____ Date of Birth: _____
 Address: _____ Telephone #: _____
 _____ Social Security #: _____

I further understand and acknowledge that in complying with my request for release, such disclosure will require Allergy & Asthma Centre to disclose, as provided under applicable federal law, Protected Health Information, as defined in 42 C.F.R. & 160 at seq.

Information to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Complete Health Record
<input type="checkbox"/> History and Physical Exam
<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Laboratory Tests
<input type="checkbox"/> Other (Please Specify) _____ |
|---|--|

I UNDERSTAND THIS MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING UNLESS EXPRESSLY EXCLUDED BY CHECKING THE BOXES BELOW:

- Acquired immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- Psychiatric Care (Behavioral Health)¹
- Treatment for Alcohol and/or Drug Abuse²
- Genetic Testing
- Sexually Transmitted Diseases (STDs)

This information is to be disclosed to: _____

I understand there may be a charge for copying my records as provided under federal and state laws.

I understand this authorization may be revoked in writing at any time by sending written notification to Allergy & Asthma Centre at 4401 4th Street N., St. Petersburg, FL 33703, except so the extent that action has been taken in reliance on their authorization. Unless otherwise revoked in writing, this authorization will expire 60 days from the date of execution. A photocopy or Fax of this document is valid as the original.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

Signature of Patient or Legal Representative: _____ Date: _____
 Witness: _____ Date: _____

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

1. Except psychotherapy notes as provided under federal and state laws.
 2. **PROHIBITION ON REDISCLOSURE:** This information has been disclosed from records whose confidentiality is protected by federal and state law. Federal Regulation (42 CFR Part 2) prohibits the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.