AUTHORIZATION FORM FOR THE TRANSFER OF MEDICAL RECORDS

This authorization may be used to permit a covered entity (as such term is defined by HIPAA) to use or disclose patient protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____ Other Name(s) Used: _____
Date of Birth: _____ Address: _____
Phone: (_____)_____ Email (*Optional*): _____

□ Allergy Asthma & Immunology is *receiving* records from the counterparty

□ Allergy Asthma & Immunology is *sending* records to the counterparty

□ **Information regarding counterparty who is sending or receiving this information:**
Name: _____
Address: _____
Phone: (_____)_____ Fax: (_____)_____

Specific information to be disclosed:
□ Medical Record from (start date) _____ to (end date) _____
□ Particular attention to include the following parts of the record (if applicable): _____
_____

Include: (Indicate by Initialing)
_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)
_____ Other *(Specify)*: _____

Reason for release of information:
□ Treatment/Continuing Medical Care
□ Personal Use □ Billing/Insurance
□ Legal Purposes □ Disability
□ School/Employment
□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) *Voluntary Authorization:* This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) *Effective Time Period:* This authorization shall be in effect until the earlier of 2 years after the death of the patient for whom this authorization is made or the following date: Month: _____ Day: _____ Year: _____.
(iii) *Right to Revoke:* I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
(iv) *Special Information:* This authorization may include disclosure of information relating to *drug, alcohol and substance abuse, mental health information, except psychotherapy notes, confidential HIV/AIDS-related information, and genetics* only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
(v) *Signature Authorization:* I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____