ADVANCED ALLERGY & ASTHMA CARE, PLLC
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS

This authorization to receive or release information is being requested of you to comply with HIPPA.

PATIENT'S NAME: _____ BIRTH DATE:_____

SOC. SEC. NO._____PHONE (WORK)_____(HOME)_____

I HEREBY AUTHORIZE:

NAME OF THE PERSON OR ORGANIZATION RELEASING INFORMATION:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

TO RELEASE INFORMATION TO:

ADVANCED ALLERGY & ASTHMA CARE, PLLC
6233 66TH STREET NORTH
PINELLAS PARK FL 33781

THIS RELEASE LIMITS DISCLOSURE TO: ☐ ALL RECORDS (OR)

☐ LAB ☐ X-RAYS /CT SCANS ☐ IMMUNIZATIONS ☐ SKIN TEST RESULTS ☐ PATCH TEST

☐ SPIROMETRY ☐ SKIN BIOPSY ☐ OTHER_____

INFORMATION NOT TO BE RELEASED, IF ANY:_____

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING(PLEASE INITIAL THE COLUMNS IF THIS INFORMATION IS TO BE INCLUDED)

	YES	NO	INITIALS
HIV INFORMATION			
DRUG/ALCOHOL INFORMATION			
MENTAL HEALTH INFORMATION			

THIS INFORMATION IS REQUIRED FOR:

☐ SECOND OPINION ☐ REFERRAL ☐ RESIDENCE RELOCATION ☐ INSURANCE CHANGE

☐ CONTINUITY OF CARE ☐ OTHER (PLEASE SPECIFY)_____

THIS AUTHORIZATION SHALL BE VALID UNTIL_____. PLEASE INDICATE THE DATE AFTER WHICH NO INFORMAITON CAN BE RELEASED. IF NO DATE IS GIVEN, CONSENT IS VALID FOR 90 DAYS ONLY.

I MAY REVOKE THIS AUHTORIZATOIN AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

COPY REQUEST: ☐ YES ☐ NO COPY RECEIEVED: ☐ YES ☐ NO

PARENT/ GUARDIAN/ AUTHORIZED REPRESENTATIVE'S SIGNATURE:_____

DATE:_____

PATIENT/PARENT/GUARDIAN NAME (PRINTED):_____