

Authorization for Release of Information for Purposes Requested by Physician's Office From Another Covered Entity

I, _____, hereby authorize _____ to disclose the following protected health information to Alabama Allergy & Asthma Center, LLC:

[Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Alabama Allergy & Asthma Center, LLC in the following manner:

[Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes.]

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Helen Combs, Privacy Officer at 10 Old Montgomery Highway, Suite 100, Birmingham, AL 35209. I understand that a revocation is not effective to the extent that Alabama Allergy & Asthma Center, LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Alabama Allergy & Asthma Center, LLC will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Personal Representative's Relationship to Patient