Timber Lane Allergy & Asthma Associates, PC
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient Name _____ Date of Birth _____ Social Security # _____

Address (Street, City, State, Zip Code) _____ Telephone Number _____

The following individual or organization is authorized to make the disclosure:

☐TO: ☐FROM:
Timber Lane Allergy & Asthma Associates, PC
☐TO: ☐FROM:
Other (*please specify*)

Name: _____
Street Address: _____
City: _____ *State*: _____ *Zip Code*: _____
Telephone: _____ *Fax*: _____

Treatment Dates: _____

Purpose of Request: _____

The following information is to be disclosed: (*Please check one box for each item.*)

YES	NO	
☐	☐	----------Physician letters
☐	☐	----------Lab results
☐	☐	----------X-ray reports
☐	☐	----------Complete record
☐	☐	----------Other (*please specify*)_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization.
Other Rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (*If I do not specify an expiration date, event or condition, this authorization will expire in one year.)*_____

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

Relationship to Patient: _____