Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

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Authorization for Disclosure of Health Information

Patient Information
Patient's name_____DOB_____
Address_____
City_____State_____Zip code_____
Phone number_____

Authorization
This authorization permits the Allergy & Asthma Diagnostic Office to release your protected health information ("PHI") to the individual or organization listed below. Signing this form is voluntary. Your decision to sign or not sign will **not** affect your ability to receive care or treatment from our office.

Person/Organization Authorized to Receive Information
Name _____
Address_____
City_____State_____Zip code_____
Phone Number_____ Fax_____

Description of Information to Be Released
Please specify the information you authorize us to release (check all that apply):

- ☐ Entire medical record
- ☐ Office visit notes
- ☐ Lab results
- ☐ Imaging / X-ray reports
- ☐ Medication list
- ☐ Immunization records
- ☐ Billing records
- ☐ Specific dates of service: _____
- ☐ Other (please specify): _____

Purpose of Disclosure
Please indicate the reason for this request (optional):_____
_____

Expiration of Authorization
This authorization is effective immediately and will remain valid until one of the options below occurs (please check and initial one):

- ☐ _____Upon completion of the requested disclosure
- ☐ _____On this specific expiration date: _____

Signature Requirements

- Patients age 18 or older must sign for themselves.
- If a legal representative is signing on behalf of the patient, documentation of legal authority (such as Power of Attorney or guardianship papers) must be provided.
- If the requested records include HIV-related information, an additional authorization form will be required in accordance with New York State Public Health Law.

_____ _____
Signature of Patient or Patient Representative Date

_____
Printed Name of Patient or Patient Representative