Allergy & Asthma

DIAGNOSTIC OFFICE

Juan L. Sotomayor, M.D. • Ellen B. Schaeffer, M.D. • Jill Agne, FNP • Katie Klee, FNP • Summer Goetz, FNP

TO: ______________________ DATE: ______________

AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient's Name: ______________________________

Patient's Date of Birth: ______________

Address: ______________________________

City: ______________________ State: __________ Zip Code ________

Phone Number: ______________

This authorization form will authorize the disclosure of your protected health information ("PHI") to the individual named below. This authorization form is voluntary, the Physician Office will not condition your treatment on the signing of this authorization form.

Description of PHI to be Disclosed. Please indicate the *specific* PHI to be disclosed. (i.e.: entire medical records, lab results, x-ray reports, specific dates of service, etc.)

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Purpose of Disclosure. Please indicate the reason for the disclosure of the above stated PHI:

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Person(s) to Whom Information May Be Disclosed. Information described above may be disclosed to:

Name ______________________________

Address ______________________________

Phone # ______________________ Fax # ______________________

Expiration Date of this Authorization. This authorization shall become effective immediately, and unless otherwise revoked, shall expire on: **(Must check & initial one of the spaces below)**

_______ Upon completion of requested disclosure ______ On ______________ (include specific date)

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that the Physician Office has already relied upon this authorization. I understand that in order to revoke this authorization, my revocation must be submitted in writing.

(Anyone, 18 or older must sign for themselves or the power of attorney must have paperwork to go along with this authorization. (If any PHI contains HIV information, another authorization will be forwarded to you that is mandated by New York Health Law)

______________________________ ______________

Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative

REV: 6-2021

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www.allergyaway.com