ATLANTA ALLERGY & ASTHMA

Authorization for Release of Medical Records

Name and address of Atlanta Allergy & Asthma office that originated this request:

_____ Fax: _____

_____ Phone: _____

MEDICAL INFORMATION RELEASE AUTHORIZATION

The undersigned patient, _____ (print name), hereby authorizes Atlanta Allergy and Asthma, P.A. (Atlanta Allergy) to release to patient and/or to _____ (name of physician or practice) a copy of the following medical record(s) of patient within Atlanta Allergy's possession or control.

By signing below, patient understands that he/she is authorizing the disclosure by Atlanta Allergy of his/her confidential and privileged medical information, including protected health information (PHI), as such term is defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such information includes personal information about the patient, including age, gender, race, date of birth, social security number and address, as well as patient's personal medical history, including diseases, afflictions, addictions, diagnoses, surgeries, disabilities and symptoms. Patient acknowledges that once Atlanta Allergy produces a copy of the confidential medical information and PHI to patient or another physician pursuant to this Authorization, Atlanta Allergy shall have no control over any subsequent disclosure or use of such information.

THE PATIENT RELEASES ATLANTA ALLERGY FROM ANY AND ALL CLAIMS, LIABILITIES, DAMAGES AND CAUSES OF ACTION WHATSOEVER ARISING FROM OR RELATED TO THE RELEASE OF PATIENT'S MEDICAL INFORMATION BY ATLANTA ALLERGY PURSUANT TO THIS AUTHORIZATION, OR ANY USE OR DISCLOSURE OF SUCH MEDICAL INFORMATION BY PATIENT OR A THIRD PARTY SUBSEQUENT TO ATLANTA ALLERGY'S DISCLOSURE OF SUCH INFORMATION.

The patient acknowledges that this Authorization shall remain in effect indefinitely or until it is withdrawn in writing by patient.

Patient/Parent Signature: _____ Date Signed: _____

Print Name: _____ Patient DOB: _____

Address: _____

_____ Daytime Phone: _____

ADDITIONAL INFORMATION:

I would like my records mailed to the following:

Name of Doctor/ Practice: _____

Mailing Address: _____ Fax : _____

_____

_____

Contact Person: _____ Phone: _____