Authorization for Release of Confidential Information

Patient Name_____ DOB_____

Every section of this form must be completed in order for this Authorization to be valid.

1. Description of information to be used or disclosed (list specific information being requested, i.e., initial appointment summary letter, pulmonary function test results, follow-up notes, or records related to a specific condition or specific time frame):_____

   _____

   _____

2. Records/Information from: Grand Rapids Allergy, PLC.

3. Release information to:

   Name_____

   Address_____

   _____

   Fax, if applicable_____

4. Reason for request_____

   _____

   _____

5. Expiration Date or Event_____

I understand that the information being used or disclosed may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, and ARC. I also understand that I have the right to revoke this Authorization by completing a Revocation of Authorization Form.

I further understand that the PHI that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my PHI. In addition, Grand Rapids Allergy, PLC will not condition treatment if this Authorization is not signed except if: 2. the treatment is related to research, or 2) the provision of health care is solely for the purpose of creating PHI so it can be disclosed to a third party.

By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my PHI in accordance with the terms of this Authorization.

Signature of Patient or Authorized Representative_____ Date_____

Description of Authorized Representative's printed authority to sign for patient_____

_____

Signature of Witness _____ Date_____

4-11 (_recordreleaseauth TO)