ASTHMA AND ALLERGY CENTER
208 MacCorkle Ave. SE, Charleston WV 25314-1160
Tel (304) 343-4300. www.asthmaweb.com
Charleston. Beckley. Parkersburg. Logan. Ripley

Authorization for Release of Protected Health Info (PHI) From AAC

Patient Name: _____ Date of Birth: _____

Street Address: _____ SSN: _____

City/State/Zip: _____ Phone #: _____

I authorize release of my **Protected Health Information (PHI) as follows:**

Release **FROM**: Asthma & Allergy Center, 208 MacCorkle Ave. SE, Charleston, WV 25314

Release **TO**: _____
Physician/Facility Name Street Address City/State/Zip Phone/Fax#

Specific information to be released:

☐ History and Physical ☐ Staff/Progress Notes ☐ Allergy Test Results

☐ Allergy Vaccine Contents ☐ Lab Test Results ☐ Other_____

☐ All dates of treatment / ___ Only these dates of treatment (specify): _____

Reason for request of records: _____

HIV, Behavioral Health and Substance Abuse information contained within the records above will be released through this authorization unless otherwise indicated below

DO NOT RELEASE: ☐ HIV; ☐ Behavioral Health; ☐ Substance Abuse; ☐ Other(specify)_____

Special Instructions:

☐ Please Fax Records to #_____
☐ Please Mail Records to the abovementioned Physician / Facility

I understand all of the following:

> The full contents of the "Notice regarding privacy of Protected Health Information" I received from Asthma & Allergy Center.
> Only the records checked above will be released to the above stated person(s) / facility(ies).
> A copy of this form will be released to the above stated person(s)/facility(ies).
> Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore Asthma & Allergy Center has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy Rule.
> I am entitled to a copy of this completed authorization form.
> This authorization is valid for one year from the date of signature unless I document a timeframe of less than one year.
> I have the right to revoke this authorization at any time by sending a written request to: Asthma & Allergy Center, 208 MacCorkle Ave SE, Charleston WV 25314, Attn: HIPAA Privacy Officer.
> I understand that my decision to revoke this authorization does not apply to any release that may have taken place prior to the date of my revocation.
> A reasonable, fee for copying, search and handling, as permitted by the state law, may be charged for copies of health care records.

Patient's Signature:_____ **Date:**_____ **Witness Signature:**_____

or

Legal Representative's Signature:_____ **Date:**_____ **Witness Signature:**_____

Relationship to Patient: *Parent of a minor / Legal Guardian / Power of Attorney /Other:* _____

Print Form

Save Form