Allergy, Asthma, Immunology Care of Central Florida

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_____ _____ _____
Patient's Name (Please print) SS or Patient Account Number Patient's DOB

I authorize _____ to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release **only** the following information (check appropriate boxes and include other information where indicated):

- ☐ Allergy Skin test results
- ☐ Most recent office notes
- ☐ Allergy Injection records
- ☐ Other (please describe): _____

_____ _____ _____
Release to institution's Name or Person Phone Number Fax Number

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other healthcare providers as needed
☐ Other (please describe):

****Please initial each item below to indicate your understanding.**

☐ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

☐ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

☐ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to:

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____ _____
Print Name Patient's Signature/Parent or Legal Guardian Date

* Please note Picture ID require for non-patient pick up. Type and ID# _____

Signature of person releasing medical records (MA, FRONT DESK, OTHER):_____

PLEASE BE ADVISED THAT WE CHARGE A $1.00 PER PAGE FOR THE FIRST 25 PAGES AND $0.25 FOR EVERY PAGE AFTER THAT.