Allergy & Asthma Care of Wylie

Patient Name: _____ Date of Birth: _____

HEALTHCARE INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

My signature on this form indicates I have received a copy of the "Notice of Privacy Practices" from **ALLERGY AND ASTHMA CARE OF WYLIE** and I understand how my healthcare information will be used and/or disclosed.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release or disclosure of all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairment, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Check all that apply: So that Dr. Fadahunsi has all the information she needs to provide medical care**,**

□ I authorize the release of my medical records to **Allergy and Asthma Care of Wylie** from **ALL MEDICAL SOURCES**

Or
□ I authorize the release of my medical records from my **PRIMARY CARE PROVIDER** (provider name and/or clinic name)_____

□ I authorize the release of my medical records to **Allergy and Asthma Care of Wylie** from **THE FOLLOWING PROVIDER(S)** (provider name and/or clinic name):_____

_____

So that other Providers have all the information needed from my care in **Allergy and Asthma Care of Wylie,**

□ I authorize **Allergy and Asthma Care of Wylie** to release my medical records to **ALL MEDICAL SOURCES.**

or
□ I authorize **Allergy and Asthma Care of Wylie** to release my medical records to my **PRIMARY CARE PROVIDER** (name and/or clinic name, fax and phone number)_____
_____
_____

The purpose for the above release of medical records is for medical care unless otherwise specified

here:_____

If you DO NOT WANT certain portions of your medical records released, please check the box indicating the information you do not want released or specify:

□ Substance Abuse □ Psychological or psychiatric treatment □ HIV/AIDS/STD
_____
_____

COMMUNICATIONS REGARDING YOUR HEALTHCARE INFORMATION

Please indicate with whom we may disclose your healthcare information. Check all that apply.

□ I authorize Allergy and Asthma Care of Wylie to leave phone messages regarding pending appointments on my phone.

□ I authorize Allergy and Asthma Care of Wylie to leave phone messages regarding test results on my phone.

□ I authorize Allergy and Asthma Care of Wylie to communicate information regarding my healthcare with the individuals listed below:

Name _____ Relationship _____
Name _____Relationship _____

□ Allergy and Asthma Care of Wylie may not communicate my healthcare information with anyone other than me.

I understand that I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

This authorization will expire one year from date signed unless otherwise specified here:_____

Printed Name of Patient or Authorized Representative _____

Signature of Patient or Authorized Representative _____

Date signed _____

Relationship to Patient:
□ Self □ Mother □ Father