GEIST CENTER FOR ALLERGY, ASTHMA IMMUNOLOGY, PC
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Authorization for Release of Protected Health Information

Patient Name: _____

Date of Birth_____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Signature: _____Date:_____

I authorize and consent to the disclosure of health records as stated below to the people I have listed. Unless limited below I understand that this release also pertains to records whose confidentiality is protected by either Federal or State regulations concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental treatment or counseling.

By signing this form I have read and understand the HIPAA policy and I am allowing /declining the release of my PHI (Protected Health Information). HIPAA policy is available if requested.

Information to be disclosed (date of service): _____

- o All Records
- o Office Visit Notes
- o Allergy Testing
- o Allergy Injections
- o Laboratory & Radiology Reports (x-ray, CT, MRI, etc.)
- o Other:_____

Information can be released to these people:

Name	Relationship	Phone number