PEDIATRIC LUNG DISEASES • ASTHMA AND ALLERGIC DISEASES OF CHILDREN AND ADULTS

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PATIENT NAME: ______________________________ **Date of Birth** ____________

Patient Address ____

City/State/Zip ______________________________ Phone: ____________

I ______________________________, hereby authorize the protected health information
(Printed Name of patient or legal representative)
regarding the above-named person be exchanged between:

To/From:

Person/Institution ______________________

Address ______________________

City ____________ State ______ Zip ______

Phone ____________ Fax# ____________

From/To:

Person/Institution ______________________

Address ______________________

City ____________ State ______ Zip ______

Phone ____________ Fax# ____________

For the purpose of: ____

This authorization will expire:

Date: ______________ Unless otherwise specified, this release will expire within one year of the date of signature.

The type of information to be used or disclosed is as follows:

- ☐ Records of all visits or specific date(s) ______________
- ☐ Copies of labs, radiographic reports, digital images, etc.
- ☐ ER/Hospital/Clinic Reports, Discharge Summaries
- ☐ Immunotherapy Shot History
- ☐ Specific Allergen Prescriptions
- ☐ Records from other physicians including consult letters/reports
- ☐ Other (please be specific) ______________
- ☐ Hepatitis information
- ☐ AIDS or HIV information
- ☐ Mental health and/or alcohol and drug abuse treatment
- ☐ Statements of charges or payments

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. North Texas Asthma & Allergy Center, its employees, officers and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed in accordance with the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.

____
Patient/Legal Representative Signature Date

____
Relationship to Patient

____
Witness Date