AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE THE RELEASE OF COPIES OF MY/MY CHILD'S MEDICAL RECORDS *FROM* THE FOLLOWING PHYSICIAN OR ORGANIZATION:

_____ Phone: _____ Fax: _____

Address: _____

TO: Allergy, Sinus and Asthma Professionals
D. Lynn Dickens, MD
950 Threadneedle, Suite 160
Houston, TX 77079
(o) 832-379-8200 (f) 832-379-8201

____**FOR TRANSFER OF MEDICAL CARE, SEND ALL RECORDS,** including all components listed below.

____**FOR COORDINATION OF MEDICAL CARE,** send the following as marked:

__History/Physical Exams __Progress Notes __Laboratory results __ X-Ray/Imaging reports
__Immunizations __Medication Lists/Allergies __Phone call records documenting treatment/discussions
__ Consult/summary letters __Allergy Skin testing __Allergy Shot formulation/administration records
Other: _____

I understand that the information in my health records 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 that the information released is for the specific purpose of caring for my health and any other use of this information without the written consent of the patient is prohibited. I wish to exclude the following information: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing this information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that 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. Unless otherwise revoked, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I may contact Debbie West, at Allergy, Sinus and Asthma Professionals, at 832-379-8200 or debbie@asapallergy.com.

Signature of Patient or Legal Representative: _____ Date: _____
Witness: _____ Date : _____

COMPLETE ONLY IF INFORMATION IS RELEASED DIRECTLY TO THE PATIENT:
I understand that my medical records may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Allergy, Sinus and Asthma Professionals, PLLC, or my physician individually liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct information.
Signature of Patient or Legal Representative: _____
Relationship to Patient (If legal representative): _____ Witness: _____