Authorization for Release of Information

Patient name: _____

Date of Birth: _____

Patient Phone #: _____

I hereby request and authorize: Great Lakes Allergy and Asthma Center, P.C.
309 W. 12th Ave., Suite 101, Sault Ste. Marie, MI 49783
Phone: (906) 253-0400, Fax: 906-253-0401

to send information to:

_____
(Name of Physician, Person, or Agency)

_____
(Address) (Fax)

the following type(s) of information from my records (and any specific portion thereof):

- ○ History and physical examination
- ○ Most current office note/ progress note
- ○ Skin testing record
- ○ PFT, Pulmonary Function Tests
- ○ X-ray/ CT scan report: _____
- ○ Other (specify): _____

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this physician, person, or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment, or payment, is not conditional upon my provision of this authorization. I intend this document to be valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:

Please Check one:
- ○ Ninety (90) days, unless I specify an earlier date here: _____ (Date)
- ○ One (1) year
- ○ The period necessary to complete all transactions related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Witness) (Title or Relationship to individual) (Signature of Parent or other legally Authorized Representative, where applicable)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____
(Date this authorization is revoked by individual) (Signature of Patient or legally Authorized Representative)

Rev. 2/2008
