ALLERGY & ASTHMA CENTER OF GEORGETOWN

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information: Full Name _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Phone (_____) _____ Email (Optional) _____

Health care provider or health care entity authorized to disclose this information:
Name _____
Address _____ City _____ State _____ Zip _____
Phone (_____) _____ Fax (_____) _____

Information regarding person or entity who can receive and use this information:
ALLERGY & ASTHMA CENTER OF GEORGETOWN
3201 SOUTH AUSTIN AVENUE, SUITE 140
GEORGETOWN, TX 78626
PHONE (512) 868-6673 FAX (512) 819-0021

Specific information to be disclosed:

- ☐ Medical Record from _____ to _____
- ☐ Skin Test Results
- ☐ Extract Prescription
- ☐ Lab/X-ray reports _____
- ☐ Complete Medical Record
- ☐ Other _____

Reason for release of information:

- ☐ Treatment/Continuing Medical Care
- ☐ Billing or Insurance
- ☐ School or Employment
- ☐ Other (specify)_____

Special Information: I consent to the release of any information related to Drug, Alcohol and Substance Abuse, Mental Health, HIV/AIDS-related, and Genetic information with the rest of my medical records. Initial_____ Date _____

The individual signing this form agrees and acknowledges as follows:
(1) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(2) Effective Time Period: This authorization shall be in effect for a one (1) year period from the date below.
(3) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
(4) Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
(5) Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Guardian Signature _____ Date _____