AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND/OR CONFIDENTIAL MEDICAL RECORDS

Midwest Allergy and Asthma Clinic, P.C.

Patient Name: _____
Date of Birth: _____ Date: _____ /_____ /_____
Patient SSN: __ __ __ - __ __ - __ __ __ __

I, the above patient, or the patient's authorized legal representative, authorize Midwest Allergy and Asthma Clinic, P.C. to:

☐ **Release** records to: ☐ **Receive** records from:

_____ _____
Name of Healthcare Facility, Physician, School, Employer, etc. Street Address

_____ (___)_____ (___)_____
City/State/Zip Code Phone Fax

The purpose of this disclosure is: ☐ Per My Request ☐ Coordinate Care ☐ Transfer Care
☐ Clinical Research ☐ School/Daycare/Employer Communication ☐ Other:_____

Specify information to be released: ☐ Most Recent Visit ☐ Past 1 Year ☐ All

Other Dates: _____ /_____ /_____ to _____ /_____ /_____

Please indicate all that apply: ☐ Office visit reports ☐ Pulmonary Function Tests ☐ X-ray Reports
☐ Laboratory Reports ☐ Medication Form for School ☐ Asthma Action Plan

☐ Special Instructions ☐ Other: _____

I specifically authorize the release of the following informaiton related to testing, diagnosis, and/or treatment for (please initial applicable line): ____ HIV (AIDS virus), ____sexually transmitted diseases, ____ mental health, or ____ drug and/or alcohol abuse.

This information may be used by: ☐ Receiving Healthcare Provider's Office ☐ School
☐ Daycare ☐ Midwest Allergy and Asthma Clinic, P.C. ☐ Employer

☐ Other: _____

I understand that my Provider may not condition my right to receive health care or benefits on my signing this authorization. When my information is used or disclosed to other parties as instructed in this authorization, I understand that my Provider may not have the ability to monitor whether my health information may be further used or disclosed by such parties, and that my health infomraiton may no longer be protected by federal and state privacy laws.

Expiration: This authorization shall expire 12 months from the date of my signature unless I indicate a different date or a specific expiration event here: _____. (☐ Until child no longer attends this school/daycare).

I understand that I may revoke or terminate this request at any time prior to release of this information by submitting a written revocation sent by certified mail or hand delivery to Midwest Allergy and Asthma Clinic, P.C., Attn: Privacy Officer, 16945 Frances Street, Omaha, NE 68130-2312.

Note: Fees for the release of medical records may apply and must be prepaid. Midwest Allergy and Asthma Clinic, P.C. has 30 days to respond to your request following the receipt of the fully completed form with all fees paid.

_____ _____
Printed Name of Patient or Legal Representative Signature of Patient or Legal Representative

_____ _____ /_____ /_____
Relationship (i.e., Patient, Parent, Legal Guardian, etc.) Date