



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

Patient Name: _____

Date: ____/____/____

Date of Birth: _____

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: *It is the responsibility of the patient/legal representative to request any records.

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 information 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 information 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