Allergy & Asthma of Southern Indiana, P.C.

HIPAA Authorization for Release of Patient Information

Phone: 812-334-1198 Fax: 812-334-1199

SECTION I- ___Facility or Physician to release records (FROM) or ___Facility or Physician to request (TO):

Name:		Relationship:
Street Address:		Telephone: Fax:
City:	State:	Zip:

Section II– Medical Records Request, mailing address:

Allergy & Asthma of Southern Indiana, 485 South Landmark Ave. Bloomington, IN 47403	
Phone: 812-334-1198	**Fax: 812-334-1199**

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION I.

Please release only specific Information as indicated below:

___ **Skin testing results** (extract recipes, recent shot record)
___ **Lab work** (CBC, SED RATE, CHEM PANEL, LFT'S, ANA, TSH, UA, IMMUNE WORK-UP) Other: _____
___ **Radiology Reports** (CXR, Sinus CT, Chest CT)
___ **Pulmonary function results** (Full PFT's if available).

_____**Other:** alcohol, mental health, HIV results/testing/treatment, or other: (Specify) _____

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization

I have the right to revoke this authorization at any time by writing to Allergy & Asthma of Southern Indiana, PC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, or eligibility benefits will not be conditioned upon my authorization of disclosure. Information disclosed under this authorization might be re-disclosed by the recipient, and the re-disclosure may no longer be protected by federal or statelaw.

Section lll: PATIENT INFORMATION:

Name:		Member ID:
Street Address:		Birth Date:
City:	State:	Zip:
Telephone:	Email:	

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney.

AUTHORIZED REPRESENTATIVE FOR THE PATIENT: (if indicated)

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip:

I, or my authorized representative, hereby authorize Allergy & Asthma of Southern Indiana, PC and their respective employees, to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below: Date or event on which this authorization will expire: _____.

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____

Patient or Authorized Representative Signature **Date**

Updated: 10/28/2015 tm