PATIENT NAME ________________________DOB _________

Authorization to Disclose Protected Personal Health Information

Asthma & Allergy Associates, PC (the practice) may use or disclose your protected health information only with your consent. Your signature below authorizes the practice to disclose information about you or your child/minor in your care as set forth in the document titled "Notice of Health Information Privacy Practices" issued to you by the practice. Your signature below authorizes the practice to electronically download your medical history including medication history as it is available from pharmacies and other medical facilities. The practice may disclose information about you without your consent to government authorities for other purposes. Examples of such uses or disclosures include suspected abuse and/or infection diseases.

You have the following rights regarding your protected health information, and the practice must act on your written request within 60 days for the following items.

1. You may request restrictions on certain uses and disclosures. The practice will review your request and decide whether to grant restrictions.
2. You may request that you receive confidential communication of protected information.
3. You may request to inspect and copy your own protected health information.
4. You may request that your information be amended.
5. You may request to revoke this authorization at any time.

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices. The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions. If you feel as though your rights have been violated, you have the right to complain to the US Department of Health and Human Services and to notify the Clinic Administrator of the practice at (719) 473-0872.

By my signature below, I agree to the terms of this authorization and agree to the terms set forth in the accompanying document titled "Notice of Health Information Privacy Practices". By my signature below, I acknowledge that I have received a copy of the practices notice of privacy practices.

I authorize the following people to be allowed access to my or my child's Protected Health Information including medical records, school forms, insurance claims, medications, financial information and research participation if applicable. I authorize the following people to pick up documents as applicable or medications on my behalf or my child's behalf.

Name_________________________________ Relationship to Patient_________________________________

Name__________________________________Relationship to Patient_________________________________

Name__________________________________Relationship to Patient_________________________________

Patient Signature:____________________________ Patient DOB_______________ Today's Date____________

Parent Guardian Signature if Patient is under age 18___________________________________ Date ___________

<u>This Authorization does not have an expiration date as it remains in effect until revoked.</u>