ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

Authorization to Disclose Protected Personal Health Information

The practice may use or disclose your protected health information only with your written authorization. You may revoke authorization.

The practice may use or disclose protected health information about you for other purposes, and without your consent, if the law requires us to disclose information to government authorities. Examples of such uses or disclosures include suspected abuse and infectious diseases.

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

- *You may request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction.*
- *You may request that you receive confidential communication of protected health information.*
- *You may request to inspect and copy your own protected health information.*
- *You may request that your information be amended.*
- *You may request a paper copy of this notice.*

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.

You may complain to the practice or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. File a complaint with the practice by writing to the Practice Administrator, Asthma & Allergy Associates, 2709 N. Tejon Street, Colorado Springs, Colorado 80907. No one will retaliate against you for filing a complaint.

For more information about this notice, contact the Practice Administrator at (719) 634-1741. Effective Date: 12-28-2000

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Today's Date:_____

The practice may use or disclose your protected health information only with your written authorization. You may revoke, in writing, authorization at any time. If you choose to restore this authorization, it must be done in writing, on a new form.

I, _____ authorize Asthma & Allergy Associates, to discuss my protected ***(printed Name of Patient)*** *health information with*

_____;

(printed Name of authorized individual; *family member, significant other, friend, etc. or N/A*)

_____

(relationship to the patient)

This authorization is good until revoked.

_____

(Signature of patient authorizing disclosure)