# Authorization For The DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_ SSN:\_\_\_-\_\_\_-\_\_\_\_

I Authorize Midwest Regional Allergy Asthma Arthritis and Osteoporosis Center, PC and staff to discuss medical and/or billing information and/or release medical information to the following person(s):

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | Relationship to Patient: |  | Phone: |  | Medical □Appointment □ Billing/Account □ |
| Name: |  | Relationship to Patient: |  | Phone: |  | Medical □Appointment □ Billing/Account □ |
| Name: |  | Relationship to Patient: |  | Phone: |  | Medical □Appointment □ Billing/Account □ |
| Name: |  | Relationship to Patient: |  | Phone: |  | Medical □Appointment □ Billing/Account □ |

If only specific information is to be released, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My preferred contact: Phone\_\_\_\_\_ Letter\_\_\_\_\_ Email\_\_\_\_\_

The office: May\_\_\_\_\_ May Not \_\_\_\_\_ leave messages about my care or appointments on an answering machine or voicemail.

Revoke: You may revoke this Authorization in writing at any time by writing to MWRAAA, except to the extent that we have already released the information in reliance of his Authorization. Unless you revoke or update this Authorization in writing, this Authorization will stay in effect for the duration of your tenure as a patient.

I understand that my medical or billing record released may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information.

I have read the above information and authorize Midwest Regional Allergy Asthma Arthritis and Osteoporosis Center, PC to disclose the identified information to the persons and for the purposes described herein I understand that by signing this document, I release and discharge Midwest Regional Allergy Asthma Arthritis and Osteoporosis Center, PC from any liability and will hold Midwest Regional Allergy Asthma Arthritis and Osteoporosis Center, PC harmless for any release pursuant to this Authorization.

|  |  |  |
| --- | --- | --- |
| Signature of Patient or Legal Representative  |  | Date |
| Witness Signature |  | Witness Printed Name |