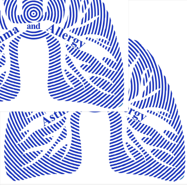

FamilyAsthma & Allergy Center
730 Woodside Rd
Redwood City CA 94061
(650) 368-8800
asthma-allergy-ca.com

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Authorization for Release of Protected Health Information (PHI)

Patient Name: ______________________________ Date of Birth: ___________

Street Address: ______________________________ SSN: _________________________

City/State/Zip: ______________________________ Phone #: ______________________

I authorize release of my **Protected Health Information (PHI) as follows:**

Release FROM: ____

Physician/Facility Name Street Address City/State/Zip Phone/Fax#

Release TO: Family Asthma & Allergy Center, 730 Woodside Road, Redwood City CA 94061

Specific information to be released:

___ History and Physical ___ Staff/Progress Notes ___ Allergy Test Results

___ Allergy Vaccine Contents ___ Lab Test Results ___ Other__________________________

___ All dates of treatment / ___ Only these dates of treatment (specify): ____________________________

Reason for request of records: ____

HIV, Behavioral Health and Substance Abuse information contained within the records above will be released through this authorization unless otherwise indicated below

DO NOT RELEASE: ___ HIV; ___ Behavioral Health; ___ Substance Abuse; ___Other(specify)________

Special Instructions:

___Please mail or **Fax: 650-368-8809** records to Family Asthma & Allergy Center at address above.
___URGENT, patient is in office waiting to be seen by the doctor.

I understand all of the following:

> The full contents of the "Notice regarding privacy of Protected Health Information" I received from Family Asthma & Allergy Center
> Only the records checked above will be released to the above stated person(s) / facility(ies).
> A copy of this form will be released to the above stated person(s)/facility(ies).
> Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore Family Asthma & Allergy Center has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy Rule.
> I am entitled to a copy of this completed authorization form.
> This authorization is valid for one year from the date of signature unless I document a timeframe of less than one year.
> I have the right to revoke this authorization at any time by sending a written request to: Family Asthma & Allergy Center, 730 Woodside Road, Redwood City CA 94061 , Attn: HIPAA Privacy Officer.
> I understand that my decision to revoke this authorization does not apply to any release that may have taken place prior to the date of my revocation.
> A reasonable, fee for copying, search and handling, as permitted by the state law, may be charged for copies of health care records.

Patient's Signature:______________________ **Date:**__________ **Witness Signature:**_______________
or
Legal Representative's Signature:____________________ **Date:**________ **Witness Signature:**_________________

Relationship to Patient: *Parent of a minor / Legal Guardian / Power of Attorney /Other:* _______________