Allergy, Asthma & Sinus Care Center
9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127
Phone 314.849.8700 | Fax 314.849.8737

# RELEASE OF MEDICAL INFORMATION

By signing this authorization, I authorize_____ to disclose certain protected health information about me to the Allergy, Asthma, and Sinus Care Center.

This information will be used for the purpose of continued medical care.

Allergy, Asthma, and Sinus Care Center will not release requested health information to a third party.

I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that unless I specifically request that such information not be disclosed, authorized disclosures may contain Protected Health Information obtaining diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse (chemical dependency), HIV and/AIDS.

I have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the entity disclosing my medical records, listed above.

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____ _____/_____/_____
Printed Patient Name (Last, First, Middle Initial) Date of Birth

_____ (_____)_____
Social Security Number Phone Number

_____
Street Address, City, State, Zip Code

_____ _____
Printed Patient/Legal Guardian Name Signature of Witness