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Ste. Genevieve | 255 Boderman Ln. | Bloomsdale, MO 63267 | Phone 314.849.8700 | Fax 314.843.8737  
Swansea | 510 Fullerton Rd. | Swansea, IL 62226 | Phone 618.233.8700 | Fax 314.843.8737

**RELEASE OF MEDICAL INFORMATION**

By signing this authorization, I authorize \_\_\_\_\_ to disclose certain protected health information about me to the Allergy, Asthma & Food Allergy Centers.

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

Allergy, Asthma & Food Allergy Centers 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