Allergy Asthma Food Allergy
Centers of St. Louis

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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.

Please read carefully. I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of any and all of my medical/health information whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. This authorization includes information presently compiled and information to be compiled during the course of treatment at Allergy, Asthma & Food Allergy Centers of St. Louis.

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.

I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my information, I can contact the Privacy Officer for this covered entity.

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

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

_____
Street Address, City, State, Zip Code

_____ _____

Printed Patient/Legal Guardian Name

Signature of Witness