HIPAA Privacy Authorization Form

To our valued patients:

We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with governmental rules, regulations, and laws. We want to ensure that our practice never contributes in any way to growing improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. You have the right to review our privacy notice, to request restrictions, and to revoke the consent in writing after you have reviewed our privacy notice.

I authorize Allergy Associates to use and disclose my PHI to the following individuals:

- ☐ Any member of my family
- ☐ Only with the following individuals: _____
- ☐ I do not give permission to share any of my medical information

The authorization for the release of information covers the period of healthcare from:

- ☐ Until cancelled by me in writing
- ☐ From ___/___/___ to ___/___/___

The person may use this medical information for medical treatment or consultation, billing, or claims payment, or other purposes I may direct. I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state.

Patient's Name and/or Authorized Representative: _____

Relationship to Patient: _____

***Patient's Signature and/or Authorized Representative: _____**

Date Signed: ___/___/___