ALLERGY & ASTHMA CARE OF INDIANA
CARMEL • INDIANAPOLIS • GREENFIELD

BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY
Treating patients of all ages

**Date**_____

GARRICK P. HUBBARD, M.D. JOEL C. SHOUSE, FNP-C ARIANA L. REYNOLDS, PA-C

Name_____ _____ _____ _____ Male/Female
Last First Middle Nickname Single/Married
Address_____City_____State_____

Zip_____ Home Phone # ( )_____ Cell Phone # ( )_____ Preference : Home/ Cell

Social Security#_____DOB_____ Email Address:_____

Employer_____Address_____

City _____ State _____Zip _____Work Phone# ( )_____

If patient is a minor, provide Mother's Name _____Father's Name _____

## PRIMARY INSURED PARTY INFORMATION

Name_____ Male Female DOB_____
Last First Middle

SS# _____Relationship to Patient _____ Home Phone# ( )_____

Address _____City _____State_____ Zip_____

Employer_____Address_____

City_____ State_____ Zip_____ Work Phone# ( ) _____

## SECONDARY INSURED PARTY INFORMATION

Name_____ Male Female DOB_____
Last First Middle

SS#_____ Relationship to Patient _____Home phone # ( )_____

Address_____City_____ State _____Zip_____

Employer_____Address_____

City_____State_____Zip_____Work Phone # ( )_____

## EMERGENCY CONTACT

Name _____Relationship _____Phone#_____Cell#_____

## PRIMARY CARE PHYSICIAN

Name _____ Address_____Phone#_____

## REFERRED BY

Name _____ Address_____Phone #_____

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## Limited Patient Authorization for Disclosure of Protected Health Information

**Form 7.31**

Please print all information. Form must be signed and dated.

**Patient Name:** _____

**SSN (last four digits):** _____ **Date of Birth:** _____

**Entity Requested to Release Information:** **Allergy & Asthma Care of IN**

**Purpose of request (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

**Who will be authorized to receive information** (the individual/entity who is to receive your PHI):

Individual/Entity Name: _____ Individual/Entity Name: _____

Phone/Fax: _____ Phone/Fax: _____

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.