Authorization for use or disclosure of Protected Health Information

SHORELINE ALLERGY AND ASTHMA ASSOCIATES, LLP

Privacy Officers: Pat, Practice Administrator and Amanda, Supervisor
Crossroads Professional Building, 196 Waterford Parkway South Ste 305B, Waterford, CT 06385
Phone: (860) 536-2995 Fax (860) 574-9170

As required by the health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the users and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I/We hereby authorize this medical practice to use and disclose health information concerning:

Patient: _____ Date of Birth: _____

Patient Address: _____

Patient Phone #: _____

I/We authorize and request that: _____
(Name of Doctor/Business to release information)

Address: _____

_____

Phone Number: (____)_____Fax : (____)_____

release copies of: _____

_____

_____

_____

_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.

This information may be sent to: SHORELINE ALLERGY AND ASTHMA ASSOCIATES, LLP

☐ 196 Waterford Parkway South Ste 305B, Waterford, CT 06385 Phone 860-536-2995 Fax 860-574-9170

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/medical health information.

Patient Signature: _____ (parent / guardian of minor child)

Print name: _____ Date: _____

Relationship to patient if not signed by patient: ☐ Parent ☐ Guardian ☐ Other _____ rev 10/2020