Allergy and Asthma Center of Birmingham, P.C.
1200 Providence Park, Suite 100
Birmingham, AL 25242
Phone: 205-995-9941 Fax: 205-995-8988

Authorization to Disclose Health Information

Patient Name:______________________________________DOB:__________________

1. I authorize Allergy and Asthma Center of Birmingham, P.C. to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

_____Problem List _____Most recent history and physical _____Laboratory Results
_____Medication List _____Most recent discharge summary _____Consult Results
_____List of Allergies _____X-Ray and imaging results _____Entire Record
_____Patient Account Statement/Billing Records

From(date)__________________________To(date)__________________________
From(date)__________________________To(date)__________________________

From: Dr. Susann Kircher, M.D. Allergy and Asthma Center of Birmingham, P.C.
Other:____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to the following individual or organization
Address:____
For the purpose:

_____At the request of the individual

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to, ____________________, Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.
6. I understand that by authorizing the disclosure of this 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 I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Susan Laurent, Privacy Officer.

Signature of patient or legal representative:_________________________________**Date:**______________

If signed by legal representative, relationship to patient:____________________**Witness signature:**______________

For Healthcare Organization Use Only

Date Received:__________________________
Patient or patient representative verified by: _______Signature on file
_______Driver's License
_______Other: ______________________________________

_______Patient given copy of signed release ________________________Staff Member Processing Request