

Allergy, Asthma & Sinus Center, P.A.

Gurdev S. Judge, MD Stephen Begley, P.A.-C

Board Certified in Allergy and Immunology - Pediatrics and Adult

Cary

401 Keisler Drive, Suite #201,
Cary, NC 27518
T: (919) 859-5966 F: (919) 859-4993

North Raleigh

10931 Raven Ridge Road, Suite #111,
Raleigh NC 27614
T: (919) 870-6440 F: (919) 859-4993

Wake Forest

1906 S. Main Street, Suite #216,
Wake Forest NC 27587
T: (919) 562-7195 F: (919) 859-4993

Authorization for Release of Protected Health Info (PHI) To AAC

Patient Name: _____ Date of Birth: _____
Street Address: _____ SSN: _____
City/State/Zip: _____ Phone #: _____

I authorize release of my **Protected Health Information (PHI)** as follows:

Release FROM: _____
Physician/Facility Name Street Address City/State/Zip Phone/Fax#

Release TO: Asthma & Allergy Center, 208 MacCorkle Ave., SE, Charleston WV 25314. Fax (304) 343-5473

Specific information to be released:

History and Physical Staff/Progress Notes Allergy Test Results
 Allergy Vaccine Contents Lab Test Results Other _____
 All dates of treatment / Only these dates of treatment (specify): _____

Reason for request of records: _____

HIV, Behavioral Health and Substance Abuse information contained within the records above will be released through this authorization unless otherwise indicated below

DO NOT RELEASE: HIV; Behavioral Health; Substance Abuse; Other(specify) _____

Special Instructions:

Please mail or **FAX (304-343-5473)** records to Asthma & Allergy Center at address above.
 URGENT, patient is in office waiting to be seen by the doctor.

I understand all of the following:

- > The full contents of the "Notice regarding privacy of Protected Health Information" I received from Asthma & Allergy Center.
- > Only the records checked above will be released to the above stated person(s) / facility(ies).
- > A copy of this form will be released to the above stated person(s)/facility(ies).
- > Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore Asthma & Allergy Center has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy Rule.
- > I am entitled to a copy of this completed authorization form.
- > This authorization is valid for one year from the date of signature unless I document a timeframe of less than one year.
- > I have the right to revoke this authorization at any time by sending a written request to: Asthma & Allergy Center, 208 MacCorkle Ave SE, Charleston WV 25314, Attn: HIPAA Privacy Officer.
- > I understand that my decision to revoke this authorization does not apply to any release that may have taken place prior to the date of my revocation.
- > A reasonable, fee for copying, search and handling, as permitted by the state law, may be charged for copies of health care records.

Patient's Signature: _____ **Date:** _____ **Witness Signature:** _____

or

Legal Representative's Signature: _____ **Date:** _____ **Witness Signature:** _____

Relationship to Patient: *Parent of a minor / Legal Guardian / Power of Attorney /Other:* _____

