CARMEL ALLERGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider; the released information may no longer be protected by federal privacy regulations.

Patient name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Date of Birth: _____

Information to be released FROM:
Facility Name: _____
Address: _____
Phone: _____
Fax: _____

Information to be released TO:
CARMEL ALLERGY (Allergy & Asthma Centers)
12750 Horseferry Road, Suite 100
Carmel, IN, 46032
Ph: 317-795-0707 F: 317-795-0706

Dates of services being requested: From _____ to _____

Check the specific information to be released:
___ **Office Notes**
___ Skin Tests/Results
___ Laboratory/Radiology reports
___ Breathing tests
___ Other (specify) _____

Purpose of disclosure:
___ **Medical Review**
___ Legal Review
___ Insurance
___ Other

The named entity is authorized to (select both if applicable): ___ Use protected health information for treatment, payment, and operations
___ Disclose protected health information to entity named

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclosure of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: _____ Date: _____

Signature of Patient or Responsible Party: _____