Allergy, Asthma & Sinus Center
Paul S. Judge, M.D.

St. Joseph (Main office)
2550 Niles Road
St. Joseph, MI 49085

Benton Harbor office
951 Pipestone Road
Benton Harbor, MI 49022

Dowagiac office
302 S. Front St, Ste. D
Dowagiac, MI 49047

PATIENT RECORDS RELEASE FORM

Name of Patient: _____ DOB: ____/____/_____

Address: _____ Phone: (_____)_____-_____

I authorize: _____ Phone: (_____)_____-_____
Establishment

Address: _____

To release the PHI (Protected Health Information) of the above named patient to:

Establishment: **Allergy, Asthma & Sinus Center** Phone: **(269) 429-1085**

Address: **2550 Niles Road, St. Joseph, MI 49085** Fax: **(269) 429-2202**

For the following reason(s): _____

_____

_____

The PHI should contain:

- The full health record
- The health record for the following time frame: _____ through _____
- A specific section of the health record: _____

I understand that this request may be revoked at any time in writing to the Allergy, Asthma & Sinus Center.

Signature of Patient: _____ Date: _____/_____/_____

Signature of Authorized Personal Representative: _____ Date: _____/_____/_____

Printed name of Authorized Personal Representative: _____

Relationship to Patient: _____

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Name of Patient: _____ DOB: ____/____/_____

Address: _____ Phone: (_____)_____-_____

I authorize: **Allergy, Asthma & Sinus Center**
2550 Niles Road
St. Joseph, MI 49085

Phone: **269-429-1085**
Fax: **269-429-2202**

To release the PHI (Protected Health Information) of the above named patient to:

Establishment: _____ Phone: (____) _____-_____

Address: _____ Fax: (____) _____-_____

For the following reason(s): _____

_____

_____

I authorize the release of information covering the period(s) of healthcare from:

Date(s)_____ To _____

The PHI should contain:

- o History and physical examination
- o Consultation reports
- o Progress notes
- o Diagnostic tests (labs, PFT's, etc.)
- o A specific section of the health record: _____

This information for which I am authorizing disclosure will be used for the following purpose:

- o My personal use (there is a fee for personal use copies)
- o Sharing with other health care providers (no charge if sent directly to the provider – address must be provided as recipient above)
- o Other (please specify)_____

This authorization will expire:

Date: _____, 20_____. If not otherwise specified this release will expire within 30 days of the date of signature.

Authorization for Release of Patient Health Information

Unless revoked, this authorization will expire 30 days from the date of signature on the front for this form.

I understand authorizing the use or disclosure of the information identified above is voluntary.

I understand that once Allergy, Asthma & Sinus Center discloses my health information to the recipient, Allergy, Asthma & Sinus center cannot guarantee that the recipient will not re-disclose my health information to a third party.

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 the HIPAA officer at the Allergy, Asthma & Sinus Center. 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.

I understand that Allergy, Asthma & Sinus Center may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Allergy, Asthma & Sinus Center to use or disclose my health information in the manner described above.

I understand that this request may be revoked at any time in writing to the Allergy, Asthma & Sinus Center.

Signature of Patient: _____ Date: _____/_____/_____

Signature of Authorized Personal Representative: _____ Date: _____/_____/_____

Printed name of Authorized Personal Representative: _____

Relationship to Patient: _____