AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(A separate form must be completed for each request and purpose. Incomplete forms will not be processed.)

Patient's Full Legal Name:_____ Date of Birth:_____

Maiden Name/Alias:_____ Phone Number:_____

Email: _____

Medical records requests may take up to 30 days to process and are completed in the order they are received.
If you need your records urgently, we will do our best to accommodate your request. Please indicate the date by which you need them here: _____.

Records to be RELEASED from FAA to party named below:

Name of Individual/Clinic/Organization:_____
Street Address:_____
City, State, Zip Code:_____
Phone:_____ Fax:_____

I would like my records release by (**circle one**):

MAIL **FAX** **ENCRYPTED EMAIL (most secure option)**

The purpose of this release is (check one):

☐ Coordination of Medical Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Personal Use

☐ Family/Friends Involved in Care ☐ Other:_____

I AUTHORIZE the following information to be disclosed (check those below that apply or ALL records will be sent):

☐ Any and ALL records
☐ Records regarding treatment for the following condition_____
☐ Records covering the period of time from _____ to _____

This release may include the following records, unless I have excluded those records by checking one or more boxes below:

☐ Mental Health ☐ HIV ☐ Substance Abuse

*I acknowledge that I am entitled to receive **my first requested copy of medical records free of charge**. If that free copy has already been provided, I understand that any **additional copies will be subject to a fee**. I further acknowledge that I will be invoiced for the amount charged and that payment must be received before any records are released.*
*I understand that I have the right to **revoke this authorization at any time** by submitting a written notice to the Privacy Officer at: **Family Allergy & Asthma** 9800 Shelbyville Road Louisville, Kentucky 40223*
*I further understand that my revocation will not affect any **use or disclosure of my information made in reliance on this authorization, or any release that occurred prior to the receipt of my revocation**. I acknowledge that **signing this authorization is voluntary**, and that **Family Allergy & Asthma will not condition treatment or payment** on whether I sign this form. I understand that information disclosed under this authorization **may be subject to re-disclosure by the recipient** and may no longer be protected under federal privacy laws and regulations. This authorization is valid for **ninety (90) days from the date of my signature**. A copy of this signed authorization will be provided to me upon request.*

_____ _____
Signature of Patient/Parent/Guardian/Personal Representative Date

ELECTRONIC SIGNATURES ACCEPTED

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MedRec@familyallergy.com

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