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Patient Name: _____ Date: _____

MEDICAL RECORDS RELEASE

I understand that providing my authorization is voluntary. I understand that the health records and information disclosed may be protected by HIPAA. I further understand that is it possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA.

_____ _____
Patient/Responsible Party Signature Date

PRIVACY PRACTICE

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this protected health information may be used: in coordination of care with other healthcare professionals, healthcare operations such as quality assessments and physician certifications and health insurance claims processing and reimbursement.

I also understand that by signing this document that Phoenix Allergy & Asthma will not give out any of my medical or non-medical information without my permission.

_____ _____
Patient/Responsible Party Signature Date