Allergy Asthma Immunology of Rochester, P.C.

Records Release Authorization

This form provides authorization to AAIR, PC to use or disclose your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it. **This form is two-sided.**

Patient Name:_____ **DOB**:_____

I authorize AAIR, PC to:

___**Send** my personal health information to: ___**Obtain** my personal health information from:

_____ _____

_____ _____

_____ _____

Phone:_____ Fax:_____ Phone:_____ Fax:_____

Please send the following information:

___Chart Notes ___Skin Tests ___Pulmonary Function Tests ___Labs/X-rays

___Extracts ___Extract Recipe ___School Form ___Camp Form

___Other (please indicate below what information you would like released):

_____

_____

_____

The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization. I understand that if my records contain information about alcohol or substance abuse, mental health treatment and/or HIV/AIDS status or testing, I authorize AAIR, PC to release such information as part of my medical record **only** if I place my initials on the appropriate line as set forth below.

Include in information to be released:

_____Alcohol/Substance Abuse Records

_____Mental Health Records

_____HIV/AIDS related records

OVER PLEASE ➔

Purpose of Information to be disclosed: _____

_____

_____

This authorization is valid for this instance of release of information only. SCHOOL or CAMP forms are valid for <u>current</u> school year or camp session only.

I understand that I have the right to revoke this records release authorization at any time, in writing, by mailing such written notification to: **AAIR, PC, ATTN: PRIVACY OFFICER**, 3136 Winton Road South, Suite 203, Rochester, NY 14623.

I understand that a revocation is not effective to the extent that AAIR, PC has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that AAIR, PC will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I can receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my personal health information as described on this form.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date Signed**

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

Return completed form to:

AAIR, PC
Attn: Office Manager
3136 Winton Road South, Suite 203
Rochester, NY 14623

Phone: 585-442-0150
Fax: 585-244-3991

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