Premier
ALLERGY, ASTHMA & SINUS CARE
John G. Latall, MD Board Certified Allergy and Immunology
Lincoln Park • Loop • Niles
T 773.665.4016 • F 773.360.6200

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Information:
Name_____ DOB_____
Address/City/State/Zip_____

By signing this request, I authorize my protected health information to be released as follows to:
Person/Provider/Institution _____
Address/City/State/Zip_____
Phone_____ Fax_____ Email_____

The purpose of this disclosure is:

- ☐ My personal use (there is a fee for personal use copies)
- ☐ Sharing with other health care providers (no fee if sent directly to the provider indicated above)
- ☐ Other (please specify)_____

Format of Disclosure:

- ☐ Copy of Record- mailed to address above
- ☐ Copy of Record to be picked up
- ☐ Verbal Release (i.e. phone conversation)
- ☐ Other (please specify)_____

- I authorize to disclose certain protected health information (PHI) about me to Premier Allergy, Asthma & Sinus, Care compliant with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge receipt of Premier Allergy, Asthma & Sinus Care Notice of Privacy Practices document which explains my rights and how my information pursuant to this authorization will be subject to use and disclosure.
- This authorization will expire on one year from the date of this release, if not otherwise specified.
- I have the right to revoke this authorization in writing at any time except to the extent that Premier Allergy, Asthma & Sinus, Care has acted in reliance upon this authorization. My written revocation must be submitted to Premier Allergy, Asthma & Sinus Care. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- I understand that Premier Allergy, Asthma & Sinus Care may directly, or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

This authorization permits Premier Allergy, Asthma & Sinus, Care to obtain and use the following health information as spelled out in the Notice of Privacy Practices which you received: **(check all that apply).**

☐ Previous blood work, radiology, spirometry and/or other test results from the past year.

☐ The most recent progress note and any progress notes over the past year dealing with possible allergic symptoms/complaints.

☐ All previous allergy testing, blood work, radiology, spirometry and/or other test results and findings, progress notes & documentation of previous and current course of therapy etc. necessary to make a smooth transition of this patient to our care.

☐ OTHER _____
(Specifically describe the information to be released, such as date(s) of service and the level of detail to be released)

If I do NOT want one or more of the following three (3) types of health information released to Premier Allergy, I understand that I must initial the following lines otherwise the health information released to Premier Allergy may include any of the following:

☐ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse.

☐ Records of HTLV-111 of HIV testing (AIDS test) results, diagnosis and/or treatment.

☐ Psychiatric, psychological records or evaluations and/or treatment for mental, physical, and/or emotional illness.

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☐ **URGENT REQUEST / PLEASE RESPOND STAT**
Patient is waiting to be seen and this information is needed.
Please be sure to include a call back number in case we have problems receiving the full transmittal.
Fax: 773-360-6200
Attn: Medical Records – Premier Allergy

I have read and understand he 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 Premier Allergy, Asthma & Sinus Care to use of disclose my health information in the manner described above.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Printed Name of Patient or Legal Guardian) (Relationship to Patient)