  

# 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 released by (**circle one**):

# MAIL FAX ENCRYPTED EMAIL (most secure option)

The purpose of this release is (check one):

 Coordination of Medical Care Family/Friends Involved in Care

Legal Purposes  Insurance Purposes  Personal Use  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

# ELECTRONIC SIGNATURES ACCEPTED

Date



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