ASTHMA, ALLERGY & IMMUNOLOGY CENTER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____
Street City State Zip

I authorize Asthma, Allergy & Immunology Center ("Practice") to disclose my individually identifiable health information, including, if applicable, records of substance use treatment, communicable diseases, HIV infection or AIDS.

1. **Recipient.** The Practice may disclose my health information to the following persons or class of persons:

   Name of Organization/Person: _____

   Address: _____

   Street City State Zip

   Phone Number: _____

2. **Specific type of information to be disclosed.** Select any of the following:

   ☐ History & Physical ☐ Treatment Records ☐ Consultation Records
   ☐ Physician Treatment Notes ☐ Physician Orders ☐ Treatment Plan

   ☐ Laboratory Reports ☐ Medication Records ☐ List of Allergies
   ☐ Immunization List ☐ X-Ray & Imaging Report

   ☐ Other (specify): _____

   Date(s) of treatment: _____

4. **The purpose and need for such disclosure**. Select one of the following:

☐ At the request of the Patient ☐ To provide continuity and coordination of care
☐ Other (specify): _____

Right to Revoke. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation the Practice's Privacy Officer at the address listed below. As provided in the Practice's Notice of Privacy Practices, the Practice may have already released the information

based on your original authorization. The Practice will not release any additional information after receiving your revocation.

Re-disclosure. However, I understand that the information I authorized a person or entity to receive may be re-disclosed and no longer protected by the federal privacy regulations.

Term. This authorization will expire 1 year from the date of signature, or until the Practice has completed the disclosure(s) you've requested, whichever is shorter.

I understand that Practice will not condition coordination of healthcare services on my signing of this document.

_____ _____

Consumer Signature Date

_____ _____

Personal Representative Signature Date

If you are signing as a personal representative of the Patient, describe this relationship and the source of your authority to sign this form below.

☐ Parent ☐ Guardian ☐ Other (specify): _____

Contact the Practice's Privacy Officer:

Zina Bachuwa
Asthma, Allergy & Immunology Center
5155 Norko Drive
Flint, MI 48507
(810) 720-6700

DET02:2033294.1