**Authorization Form for Release of Protected Health Information**

**By signing this form, I authorize you to use and disclose protected health information described below.**

**Release my protected health information to the following person(s)/entity:**

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 Initial here if you **do not** choose to release your protected information to anyone.

**If you choose to release information to the specified person (s) above, indicate which health information you may release subject to this authorization (i.e. office visit notes, skin test, billing, etc):**

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 Initial here to release all medical and personal information.

**If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.**

 Initial here for indefinite authorization.

**I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following address:**

**Allergy & Asthma Centres of the Metroplex, 5421 Matlock Rd., Arlington, TX 76018- Attn: Privacy Officer- Fax 817-461-0809**

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that this information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

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Signature of Patient or Parent/Legal Guardian Today’s date

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**Print Name of Patient or Parent/ Legal Guardian Patient Date of Birth**