Relief
Allergy & Sinus Institute

(630) 513-1691
reliefasi.com

Authorization To View/Disclose/Copy PHI

Patient Name: ____________________ Phone: ____________

Address: ____

Social Security #: ____________ Date of Birth: __________

I authorize the use, copying and/or disclosure of the above-named patient's health information as described below:

FROM: Relief Allergy & Sinus Institute

TO:

- ❑ Parent(s) or guardian (Name) ______________________________
- ❑ Relative or other family member (please specify by name and relationship to patient)

  ____

- ❑ Other (please specify):
  - Name: ______________________________
  - Address: ______________________________
  - City, State, Zip: ______________________________

FOR THE PURPOSE OF: (Check all that apply.)

- ❑ Viewing Health Information Only (Inspect)
- ❑ Continued Care (Pt Moving or Relocating – Fill out back of form)
- ❑ Continued Care (Referral/Consult/Communication)
- ❑ Legal
- ❑ Insurance
- ❑ Copying at Request of Patient
- ❑ Other (explain)

  ____

INFORMATION TO BE VIEWED, DISCLOSED AND/OR COPIED:
The type and amount of information to be used, disclosed, or copied is as follows: (include dates where appropriate)

- ❑ Record Abstract
- ❑ History & Physical
- ❑ Entire Record
- ❑ Laboratory Results from (date) ____________ to (date) ____________
- ❑ X-ray and Imaging Reports from (date) ____________ to (date) ____________
- ❑ Consultation Reports from (doctors' names) ______________________
- ❑ Other ______________________________
- ❑ List of Allergies
- ❑ Skin Test Results

This authorization automatically expires 365 days from the date this authorization is signed by the patient below unless otherwise noted ______________________.

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This authorization provides that:

- I may revoke this authorization at any time, provided the revocation is in writing to the Privacy Official at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance.
- I understand that if the person(s) or entity receiving this authorized PHI is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer by protected by federal or state law.
- This practice will not withhold treatment for my condition, on my providing authorization for the requested use of disclosure.

____ ______________
Signature of Patient or Authorized Representative Date

____ ______________
If Signed by Authorized Representative, Relationship to Patient Date

____ ______________
Signature of Witness Date

If unable to sign document, give reason ______________________________________

Identification verified ________________
Initials

NOTE: Re-disclosure of this information may be permitted.

NOTE: If you are requesting records due to a move or relocation, please fill out the forwarding address and phone information below:

New Address: ____

Contact Phone Number: _________________________

Our practice charges a nominal fee for the copying of PHI records. If you ask us to mail your requested records, a fee to cover postage will be added to the copying fee. Please contact our Privacy Official if you have any questions relating to your request to copy records.

You have a right to a copy of this form after you sign it.

FOR OFFICE USE ONLY

Physician Review of Request: _________________
(Initials)

Request Granted: _________________________ **Date:** ___________________
(Initials)

Request Denied: _________________________ **Date:** ___________________
(Initials)

Fee Paid $___________