Allergy and Asthma Clinic, PC

Medical Information Release Form / HIPPA Release Form

Patient Name:_____ Date of birth:_____

Release of Information

I grant permission to Allergy and Asthma Clinic, PC to disclose my protected health information to the following individual(s). If anyone other than the person(s) listed below should call or ask for information, they will be denied. If I chose not to have my information released to anyone, then I am agreeing that I am the only person that can receive my information. (Check at least one below)

___ Spouse _____

___ Child(ren)_____

___Other _____

___Information is not to be released to anyone.

Please let us know which numbers we can call to reach you

___My home # _____

___My cell number _____

___My work number _____

___Email _____

Please check a box below

____You may leave a detailed message

____Please leave a message asking me to return your call

This Release of information will remain in effect until terminated by me in writing.

Signature

_____ Date: _____

Please Print

_____