Authorization for use or disclosure of Protected Health Information

SHORELINE ALLERGY AND ASTHMA ASSOCIATES, LLP

Privacy Officers: Pat, Practice Administrator and Amanda, Supervisor
23 Clara Drive, Mystic, CT 06355 and 314 Flanders Road, East Lyme, CT 06333
Phone Numbers: Mystic Office (860) 536-2995 Fax (860) 536-7098
East Lyme Office (860) 739-3011 Fax (860) 739-3023

As required by the health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the users and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I/We hereby authorize this medical practice to use and disclose health information concerning:

Patient: _____ Date of Birth: _____

Patient Address: _____

Patient Phone #: _____

I/We authorize and request that Shoreline Allergy and Asthma release copies of:

_____

_____

_____

_____

Shoreline Allergy does not charge for the last two office notes, consultation (summary) note or current year test results. Unless indicated, this will be the records provided. All past medical records will be provided at a copying fee of $.65 per page. Shoreline Allergy CANNOT release records provided to us by another physician.

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.

This information may be sent to: ☐ Patient ☐ Physician's Office ☐ Other: _____

Name of practice/entity receiving information: _____

Address: _____

_____

Phone Number: (____)_____Fax : (___)_____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/medical health information.

Patient Signature: _____ (parent / guardian of minor child)

Print name: _____ Date: _____

Relationship to patient if not signed by patient: ☐ parent ☐ Guardian ☐ Other _____