WELCH PASTEUR ALLERGY MEDICAL GROUP
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211 QUARRY ROAD SUITE 106, MAIL CODE 5996
PALO ALTO CA, 94304
PH: 650-322-3847 FAX: 650-322-3249

Authorization for Release of Protected Health Information

Patient Name:_____ Date of Birth:_____
Address:_____ City:_____ Zip Code:_____
Phone #:_____

I authorize release of my Protected Health Information as follows:

Release From:
Physician/Facility Name:_____
Address:_____ City:_____ Zip Code:_____
Office Phone Number:_____ Office Fax Number:_____

Release To:
Physician/Facility Name/Other:_____
Address:_____ City:_____ Zip Code:_____
Phone Number:_____ Fax Number:_____

Specific Information to be released: (please check all that apply)

_____Complete Medical Record
_____Composition of Antigens
_____Diagnosis
_____Skin Test Results
_____Office Visits
_____Lab Results
_____All dates of Treatment
_____Only Specific Dates:_____

Reason for request of records:_____

I understand all of the following:
» Only the records checked above will be release to the above stated Person/Facility
» A copy of this form will be released to the above stated Person/Facility
» Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, Welch Pasteur Allergy Medical Group, Inc. has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy rule.
»I am entitled to a copy of this completed authorization form.
»This authorization is valid for one year from the date of signature unless I document a time frame of less than one year.
»I have a right to revoke this authorization at any time by sending a written request to: Welch Pasteur Allergy Medical Group, Inc, 211 Quarry Road Suite 106, Mail Code 5996, Palo Alto, CA 94304, Attn: HIPAA Privacy Officer.
»I understand that my decision to revoke this authorization does not apply to any release that may have taken place prior to the date of my revocation.
»A reasonable, fee for copying, search and handling, as permitted by the state law, may be charged for copies of health care records.

Patient's Signature:_____ Date:_____

If under 18
Parent's Name:_____ Parent's Signature:_____ Date:_____

For Office Use Only:
Completed Date:___/___/____ Initials:_____ Faxed _____Mailed _____Patient Picked up_____