

**ACADEMY ALLERGY ASTHMA & SINUS, P.C.**

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**Authorization for Release of Protected Health Information**

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

I hereby authorize and consent to disclosure of health records as stated below. Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 C.R.F., Part 2) or State Regulations (I.C. 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.**

1. Information to be disclosed (dates of service): \_\_\_\_\_

- Office Visit/Progress Notes
- Allergy Testing
- Allergy Injection Records & Allergy Serum Formula/Recipe
- Laboratory Reports
- Radiology Reports (x-ray, CT, MRI, etc.)
- Other: \_\_\_\_\_
- I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

2. I authorize Academy Allergy Asthma & Sinus, P.C. to release information to: (include address, phone & fax)

\_\_\_\_\_

3. I authorize Academy Allergy Asthma & Sinus, P.C. to obtain information from: (include address, phone & fax)

\_\_\_\_\_

4. The purpose or need for this disclosure is \_\_\_\_\_

5. This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. This will not exceed 60 days from the date of signature.

6. This authorization may be revoked at any time, except to the extent that action has already been taken. To revoke this authorization, I will notify the Privacy Contact in writing.

7. Information to be released in the following manner:

- Verbally
- Photocopy
- Faxed

8. I understand that the information used or disclosed may be subject to redisclosure by the person (s) or class of person (s) receiving it and no longer protected by the federal privacy regulations.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

If Personal Representative: \_\_\_\_\_  
Name of Personal Representative

\_\_\_\_\_  
Description of Representative's Authority to Act for the Patient