AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION

I hereby authorize *MEDICAL ARTS ALLERGY P.C.* to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

****Patient name: _____ Birth Date: _____**

Organization Providing the Information:
Medical Arts Allergy, PC

****Designated Party to: _____Relationship to Patient: _____**

Address:_____ Phone: _____

Specific Description of Information Disclosed: Entire Medical Record

_____

NOTE: Mental health and substance abuse treatment and HIV-related information contained in the specific description of information to be disclosed will be included unless specifically requested to be excluded.

****If you wish to exclude any of the following please initial**

Initials: _____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;
Initials: _____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information;
Initials: _____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
Initials: _____ venereal disease information;
Initials: _____ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure: Medical Treatment

The information will be used or disclosed for the following purposes:
[ ] At the request of the individual [ ] Other: _____

Date of Services: _____/_____/_____ (MM/DD/YEAR)

The patient or the patient's representative must read and initial the following statements:

Must Check One

1. I understand that this authorization will:
   [ ] expire on _____ /_____/_____(MM/DD/YEAR)
   [ ] expire 7 years from the date signed by the patient or patient's representative; or
   [ ] be effective for the lifetime of the patient unless revoked (see #2 below)

2. I understand that I may revoke this authorization at any time by notifying Medical Arts Allergy, PC in writing; however, if I do revoke the authorization, it will not have any affect on any actions taken by Medical Arts Allergy, PC prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether I sign this Authorization.

X_____ _____

Signature of patient or patient's representative **Date**

(*Form **MUST** be completed before signing or will not be valid)*

Printed Name of Patient's Representative: _____

Relationship to Patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION