Arizona Asthma & Allergy INSTITUTE
www.azsneeze.com

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Authorization for Arizona Asthma and Allergy Institute to
Use or Disclose My Health Information (Medical Records Request)

Patient Name: _____ Acct#_____ Date of Birth:_____

I. My Authorization
You may use or disclose the following health care information (check all that applies):

- ☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health care/Psychiatric Care, Alcohol and/ or Drug Abuse Treatment, if any unless specifically excepted:_____
- ☐ My health information for the date(s):_____
- ☐ X-ray films/reports (specify date) _____
  X-rays are the property of Arizona Asthma & Allergy Institute and the patient is responsible for returning them promptly.

You may *disclose* **this information to:**
Name (or title) and organization _____
Address: _____
City: _____ State: _____ Zip Code: _____
(circle one)
Mail/ Pick Up/ Fax # _____ Authorized person to pick up records: _____

You may *request* my health information from:
Name (or title) and organization _____
Address: _____
City: _____ State: _____ Zip Code: _____
Reason(s) for this authorization (check all that apply):

- ☐ At my request _____ This authorization ends on (date) _____
- ☐ Other (specify) _____

II. My Rights
I understand that I do have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from this office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it. I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name Relationship (parent, legal guardian)