AUTHORIZATION FOR RELEASE OF INFORMATION TO PREMIER ALLERGY & ASTHMA

Complete for All Authorizations

I hereby authorize the use or disclosure of my individually identifiable health information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

This form is not necessary to release information for treatment or payment purposes except if the information to be released is psychotherapy notes or certain research information.

Patient Name:_____ **DOB:**_____

Persons/organizations authorized to **release** your PHI

Name: ___

Phone: _____

Fax: _____

Address: ___

Persons/organizations authorized to **receive** your PHI

premier allergy & asthma
19245 E Smoky Hill Rd Ste A
Centennial, CO 80015
P: 303.468.8668 F: 303.468.8669

Specific description of PHI to be released:

_____ _____

Specific restrictions you want placed on release of your PHI:

_____

Purpose for Releasing Information:

☐ Continuation of Care ☐Insurance ☐Legal ☐Personal Use ☐Other: _____

I understand that this authorization will expire a year from now unless otherwise specified **Initials** ____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation. **Initials** ____

I understand that I am not required to sign this authorization form **Initials**_____

I understand that my health care and the payment for my healthcare will not be affected if I do not sign this form. **Initials**_____

I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I can receive a copy of this form after I sign it. **Initials**_____

Fees:

Pages	Release to Patient
1-10	$15.00
11-40	$0.50 per page
41+	$0.25 per page

According to Colorado Revised Statues, Title 25, Article 1, Part 8 25-1-801 (A) the following fees may be charged for copies of medical records.

Records will be provided to other health care providers at no charge.

If Signed by Authorized Representative:

If Signed by Patient:

_____

Signature

_____

Printed Name

_____

AUTHORIZATION FOR RELEASE OF INFORMATION FROM PREMIER ALLERGY & ASTHMA

Date

Signature

_____

Printed Name

_____

Relationship to Patient

_____

Date

19245 E. Smoky Hill Road, Suite A, Centennial, CO 80015
P: 303.468.8668 F: 303.468.8669
premierallergy.com