TALLAHASSEE
ALLERGY, ASTHMA & IMMUNOLOGY
SPECIALIZING IN ADULT AND PEDIATRIC ALLERGIC DISORDERS

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THIS IS AN AUTHORIZATION TO OBTAIN, USE, AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

✱Patient Last Name _____ ✱Patient First Name _____ Middle Initial _____

Previous Name _____ ✱DOB _____ Gender _____ SSN _____

Patient Home Address _____

City _____ State _____ Zip _____ Patient Home Phone _____

1. I authorize Tallahassee Allergy, Asthma & Immunology to obtain and/or disclose a copy of the health information described below
(Please check one: ☐ To be obtained **FROM** OR ☐ To be disclosed **TO**)

✱Name _____ ✱Phone Number _____ Fax Number _____

Mailing Address _____

City _____ State _____ Zip _____

1 (a). Information to be released: ☐ **Complete Medical Record** ☐ **Lab Results** ☐ **OTHER:** _____

☐ **Specific information: NOTES ON CONDITIONS RELATED TO ALLERGY, ASTHMA and IMMUNOLOGY**

1 (b). Purpose or need for the information is (optional): _____

2. I understand that the information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I can **revoke** this authorization at any time by sending my written request to: TAAI at PO Box 13058, Tallahassee, FL 32317. Such written revocation will be effective only after receipt and processing by TAAI. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in the authorization. I understand that the revocation will not apply to information that has already been obtained, used and/or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. Unless revoked, this authorization will **expire** on the following date, event or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will automatically expire in twelve (12) months from the date of my request.

5. I understand that a disclosure of information under this authorization carries with it the potential for **re-disclosure** by the recipient and that the information may no longer be protected by federal confidentiality rules. If I have questions about the uses and disclosures of my health information at TAAI, I can contact: TAAI at PO Box 13058, Tallahassee, FL 32317; (850) 656-7720.

✱ _____ _____
Signature of Patient or Personal Representative* Printed Name of Patient or Personal Representative*

_____ _____
Date *Relationship to Patient (if Personal Representative