Roanoke
1505 Franklin Road SW
Roanoke, VA 24016
Ph: 540-343-7331
Fax:540-343-7349

Salem Office
3529 Keagy Road
Salem, VA 24153
Ph: 540-981-5653
Fax: 540-725-1356

Lynchburg Office
2015 Tate Springs Road Suite A2
Lynchburg, VA 24501
Ph: 434-846-2244
Fax: 434-846-0602

Authorization for Use or Disclosure of Information

Patient Name: _____ _____Date of Birth: _____

Guardian/ Representative (if applicable) _____

Relationship to Patient: _____

I, the undersigned, hereby authorize The Asthma & Allergy Center to disclose the following protected health information (PHI): Please check the applicable box(es)

☐ **Limited information:** _____
(Please list the limited information you wish to disclose.)

☐ **My complete medical record, including lab work and test results.**

To the following entities: _____
(Please list the medical practice name or the name of the physician who will receive your records.)

Phone: _____ Fax: _____
(Please provide the medical practice phone and fax numbers to which your records will be sent.)

For the following use or purpose(s):
_____
_____

This authorization shall expire on this date: _____

I understand that I have the right to revoke this authorization in writing at any time by sending written notice to Cari Humphries at the Roanoke address listed above. I understand that revocation is not effective to the extent that The Asthma & Allergy Center has relied on the use or disclosure of the PHI. I further understand that, in accordance with state and federal law, there may be a charge associated with copying my records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Asthma & Allergy Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
- Refuse to sign this authorization.

Signature: _____**Date:** _____