Asthma & Allergy CENTER

Roanoke
1505 Franklin Rd. SW
Roanoke, VA 24016
T (540) 343-7331
F (540) 343-7349

Lynchburg
2015 Tate Springs Rd.
Lynchburg, VA 24501
T (434) 846-2244
F (434) 846-0602

Salem
3529 Keagy Rd.
Salem, VA 24153
T (540) 343-7331
F (540) 725-1356

Request for Release of Information to Asthma & Allergy Center

Patient Name: _____ Date of Birth: _____

Guardian/ Representative (if applicable): _____

Relationship to Patient: _____

I, the undersigned, hereby authorize the following entity:

_____

To disclose the following protected health information (PHI) to the Asthma & Allergy Center:

_____

_____

To be used or disclosed to carry out treatment, payment or health care operations in the following manner: _____

_____

This authorization shall expire: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jason Call at 1505 Franklin Rd SW, Roanoke, VA 24016 or by email at jcall@asthmaandallergycenter.net. I understand that a revocation is not effective to the extent that Asthma & Allergy Center has relied on the use or disclosure of the PHI. 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 (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name Relationship to Patient