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

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):

_____

_____

To the following entities:

_____

For the following use or purpose(s):

_____

_____

This authorization shall expire: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Cari Humphries at the Roanoke address listed above. I understand that a 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: _____