TOTTORI ALLERGY & ASTHMA ASSOCIATES
AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

☐ **STAT REQUEST**

Facility Name/Provider: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City/State/Zip: _____

Below listed patient and/or guardian authorizes the following healthcare facility to make record disclosure

Patient Name: _____ **Date of Birth:** _____

Phone (H): _____ **Phone (W):** _____

Address: _____ **City/State/Zip:** _____

☐ **Dates and Type of Information to Disclose:**
Entire Medical Records
Dates (Other): _____
I am authorizing the following information be disclosed:
Check all that apply:
☐ HIV/AIDS
☐ DRUG/ALCOHOL ABUSE/TREATMENT
☐ MENTAL/BEHAVIORAL HEALTH CONDITIONS

☐ **The Purpose of Disclosure is:**
Change of Insurance or Physician
Continuation of Care
Referral/Other: _____

This information may be disclosed and used by the following individual or organization:

Send/Release Records To: _____

Address: _____

City/State/Zip: _____ **Phone:** _____ **Fax:** _____

Right to Revoke This Authorization: I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to this healthcare provider. I understand that the revocation will not apply to information that has already been released in response to 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. **Unless otherwise 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 expire 1 year from the date signed.**
Right to Refuse to Sign This Authorization: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. **Right to Receive to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed:** I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. **Right to Receive a Copy of This Authorization:** I understand that if I agree to this authorization, I may receive a copy. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office authorized individual or origination making disclosure. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State Laws and a list of those persons/organizations is available upon request. **Copy, Electronic or Facsimile (Fax) Valid as an Original.**

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**

_____ _____
Printed Name of Authorized Representative Relationship/Capacity to Patient

_____
Address and Telephone Number of Authorized Representative