ARKANSAS
ALLERGY AND ASTHMA CLINIC
A TRADITION OF QUALITY PATIENT CARE SINCE 1930

Arkansas Allergy & Asthma Clinic, P.A.
P. O. Box 55090
Little Rock, AR 72215
Phone: (501) 227-5210
Fax: (501) 312-1592

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

1. Who is authorized to use/disclose the information:_____
2. Who is authorized to receive the information: _____
   _____
3. Description of information that may be used/disclosed; and the dates of such information (for example, nurses notes from 01-01-17 to 01-15-17):_____
   _____
4. The information will be used/disclosed for the following purposes: _____
   _____
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that Arkansas Allergy & Asthma Clinic, P.A. may be paid for the costs of copying the information to be released.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Allergy & Asthma Clinic, P.A. except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Printed Name

_____ _____
Patient's Date of Birth Patient's SSN

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

_____ _____
Witness Date