EXPERT SLEEP MEDICINE
A DIVISION OF FAMILY ALLERGY & ASTHMA

FAMILY Allergy & Asthma

AAAC ARKANSAS ALLERGY AND ASTHMA CLINIC
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(A separate form must be completed for each patient. Incomplete forms will not be processed.)

Patient's Full Legal Name:_______________________________________ Date of Birth:________________

Maiden Name/Alias:_____________________________ Phone Number:______________________________

Medical records requests take up to 30 days to complete and are processed in the order in which they are received. However, if you have an upcoming appointment we will try our best to accommodate if you enter the appointment date here: ____________________.

Records to be RELEASED from FAA to party named below:

Name of Individual/Clinic/Organization:____

Street Address:____

City, State, Zip Code:____

Phone:____________________________________ Fax:_______________________________________

I would like my records released by (**circle one**):

MAIL **FAX** **PICKED UP** at Family Allergy / Expert Sleep location: ________________________

If records are to be picked up by someone other than myself:

I authorize _____________________________ to pick up these records on my behalf. I understand a photo ID will be required to confirm his/her identity.

The purpose of this release is:

☐ Continued Medical Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Personal Use

☐ Other: ____

I AUTHORIZE the following information to be disclosed (check those below that apply or ALL records will be sent):

☐ Any and ALL records
☐ Records regarding treatment for the following condition________________________________
☐ Records covering the period of time from ____________________ to ____________________

This release includes the following records, unless I have excluded those records by checking one or more boxes below:

☐ Mental Health ☐ HIV ☐ Substance Abuse

*I acknowledge **this is my one and only free copy of my medical records**. If my free copy has already been released, I understand that I will be billed at $1.00 per page. I also understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Privacy Officer, Family Allergy & Asthma, 9800 Shelbyville Road, Louisville, Kentucky 40223. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Family Allergy & Asthma may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. **This authorization expires ninety (90) days from the date of signature**. A copy of this authorization will be provided to me upon request.*

____ ____________________

Signature of Patient/Parent/Guardian/Personal Representative Date