ALLERGY & ASTHMA CONSULTANTS, L.L.P.
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PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE AND CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I authorize this facility to speak to the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

☐ Only the following types of information:

_____

_____

The above medical information shall only be released to the following persons:

Family Member/Personal Representative	Relationship to Patient
_____	_____
_____	_____
_____	_____

It is the policy of Allergy & Asthma Consultants, L.L.P. to leave messages for patients regarding lab/x-ray/CT results, appointments and when returning calls. Please list the authorized phone number(s) where a confidential message can be left for the patient.

Primary Message Phone No.: (_____)_____ Secondary Message Phone No.: (_____)_____

I understand that I may terminate this Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one):

☐ Until revoked in writing

☐ Until _____ , 20 ____

I know that I am entitled to receive a copy of this agreement.

_____ _____
Patient Name Date

_____
Patient Signature

Patient Label