DEARBORN ALLERGY & ASTHMA CLINIC, PC
19855 W. Outer Drive Ste 204E Dearborn, MI 48124 313-565-3565 Fax: 313-565-7723

Authorization For – Use or Disclosure of PHI

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or entity authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

____ ____
Patient Name Patient ID (Office Use)

____ ____
Entity Authorized to Provide Information Person/Entity Authorized to Receive Information

History & Physical
Consultations Lab Results X-Ray Report Allergy Injection Record
Other (please note below)

____
____
____
Specific description of information (including dates):

____
____
____
The purpose of the use or disclosure is:

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ____ No _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials _____

I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
Initials _____

I understand that this authorization will expire on __________________. Initials _____

I understand that I may revoke this authorization at any time by written notice to Dearborn Allergy & Asthma Clinic, PC. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by Dearborn Allergy & Asthma Clinic, PC before Dearborn Allergy & Asthma Clinic, PC received the revocation. I also understand that more information regarding revocation of this authorization may be covered in Dearborn Allergy & Asthma Clinic, PC's Notice of Privacy Practices.

____ ______________________________________
Signature of Individual or Guardian or Individual's Legal Representative Date

____
Printed Name, Relationship of Legal Representative to Individual

YOU MAY EXERCISE YOUR RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION