Patient's Authorization to Release Medical Records

Please provide complete and accurate information when submitting this form.

The Allergy Center at Brookstone will only process valid and complete authorization forms.

Whose records are being requested or released?

Patient Name		Telephone #	
Address		Date of Birth	
City, ST Zip		Soc. Security #	

I authorize release of my (my minor child's) health care information concerning the following: (please check at least one)

- ❑ All Health Care Records
- ❑ Treatment of this condition: _____
- ❑ Treatment received on the following dates: from _____ to _____
- ❑ Other: _____

Sensitive records require specific patient authorization. Please initial the appropriate records requested: I authorize the information listed below to be used, disclosed or received:

____ Mental Health ____ STD's including HIV/AIDS ____ Drug/alcohol abuse diagnosis, prognosis, or treatment

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Who needs to receive a copy of your records? *(Check ONE Box)*

❑ I would like The Allergy Center at Brookstone to release my personal health care information to the facility listed below.

❑ I would like the facility listed below to release my personal health care information to The Allergy Center at Brookstone located at: **1220 Brookstone Centre Pkwy, Columbus, GA 31904. Phone: 706-324-4012 Fax: 706-324-0396**

Facility		Doctor	
Address		Telephone #	
City, ST Zip		Fax #	

Why are these records being requested or released?

❑ Transfer of Care ❑ Moving ❑ Other Reason: _____

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I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective when The Allergy Center at Brookstone has already relied on the use or disclosure of the health information or if authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, write a letter to The Allergy Center at Brookstone Medical Records Department.

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected under federal or state law.

I understand that I do not have to sign this authorization in order to get my health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) the healthcare services are provided to me solely for the purpose of created protected health information for disclosure to a third party, or (3) an authorization may result in inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I herby agree and authorize the release of patient health information to the aforementioned person or organization.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient please complete the section below.

Personal Representative's Name: _____

Signature: _____ Relationship: _____

This authorization is valid for one year from date unless specified.

**In most cases a first request for record copies has no charge; however, The Allergy Center at Brookstone reserves the right to charge for additional requests for the same records.*

1220 Brookstone Centre Parkway • Columbus, GA 31904
Phone: 706-324-4012 • Fax: 706-324-0396 • www.allergybrookstone.com