Michael Park, MD

Park Allergy Center

NOTES: Ex. Date of appointment at another office.

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name:_____

SSN (last four digits):_____ **Date of Birth:**_____

Name of Individual/Entity to RECEIVE records:

Name:_____

Address:_____

Phone:_____ Fax:_____

Name of Individual/Entity to SEND records:

Name_____

Address:_____

Phone:_____ Fax:_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

___Entire patient record;

Or, check only those items of the record to be disclosed:

___Office notes ___Lab results, Pathology reports ___X-Rays ___Financial history report (previous 3 years only)

___Other:_____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

_____Patient request ____Other (please specify):_____

- I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s)/entity listed.

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative signature:_____ Date:_____

Patient or representative signature:_____ Date:_____

You have the right to receive a copy of signed authorizations upon request.