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Patient Disclosure Form

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves. Not even to parents of 18 year old patients, grandparents that baby-sit or nannies. For that reason, please list the names of all family members, friends, school nurse, etc. that you give us permission to release information to about you or your child's care. If anyone not listed on this form calls or otherwise asks us for information about you or your child (even for information as basic as when your next appointment is or how to give your child's medication), we will have to refuse to give them that information until we get your expressed permission to do so.

I authorize and agree that Arcadia Allergy & Asthma may disclose my Protected Health Information to the following:

Name	Relationship
1.____________________	____________________
2.____________________	____________________
3.____________________	____________________
4.____________________	____________________
5.____________________	____________________

Authorization for Disclosure of Information

I give permission to leave a detailed voice mail regarding:
☐ All information regarding my medical care at Arcadia Allergy & Asthma

Or only the following:
☐ Medication/pharmacy information
☐ Lab/test/X-ray results
☐ Information regarding upcoming testing/appointments/allergy injections
☐ Insurance/billing information
At the following telephone number(s):____

I acknowledge and agree that Arcadia Allergy & Asthma may disclose my Protected Health Information to the persons or telephone number set forth on this form, unless and until I object to such disclosure, which will be provided in writing to Arcadia Allergy & Asthma.

Patient Name:______________________________Dob:____________________

Date:____________________ ____
Signature of Patient/Patient's Personal Representative/Legal Guardian