Allergy Associates of Hartford, PC

PATIENT INFORMATION:

Name	Address	City	State	Zip
	( )			
Date of Birth	Daytime Phone	Previous Name		

AUTHORIZES:

Name of Health Care Provider/Plan/Other

Address

TO DISCLOSE TO:

☐ **Mail to self**	☐ **Pick up**		

☐ **Send to:** _____

Name of Health Care Provider/Plan/Other

_____

Address

DATES OF INFORMATION TO BE DISCLOSED: From _____ to _____ **if left blank, only information from the past two (2) years will be disclosed.** (month/yr) (month/yr)

INFORMATION TO BE DISCLOSED:

☐ All medical records related to (specify condition, treatment, etc)_____

☐ Specific records/information as follows: _____

_____

EXPIRATION: This authorization is good until the follow date/event: _____
Note: if this item is left blank, the authorization will expire in one (1) year from the date signed.

PURPOSE: (check all that apply- copay fees may apply)

☐ Further Medical Care
☐ Insurance Eligibility/Benefits
☐ Personal
☐ Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for records copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if singing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal law.

SIGNATURE OF PATIENT/LEGAL REP_____ **Date:** _____

If signed by a person other than the patient, complete the following:

1. Individual is:	☐ A minor	☐ Legally incompetent or incapacitated		☐ Deceased
2. Legal Authority	☐ Parent	☐ Legal guardian	☐ Next of kin/executor of deceased	

Completed by: _____ # of pages released: _____