Allergy and Asthma Care of St. Louis
AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

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 organization 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 and may be redisclosed.

Patient Name:____ ID Number:____________________

Patient Date of Birth:________________ Patient Social Security Number: _____________________

Persons/organizations providing information:

Gary M. Goodman, M.D., Michele E. Kemp, M.D.,
Stephanie S. Park, M.D. and Douglas R. Berson, M.D.
Allergy & Asthma Care of St. Louis
1585 Woodlake Drive, Suite 201
Chesterfield, Mo 63017
Phone: 314-878-2788
Fax: 314-878-8988

Persons/organizations receiving information:

____
____
____
____
____

Specific description of information to be used or disclosed:

____
____
____

Patient must specify if any of these records are to be released:

___Ob/Gyn ___Substance Use/Abuse ___HIV Testing/Treatment ___Psychiatric

Specific purpose for use or disclosure:

____
____

This Authorization is for information relating to the period from ___________________ to ___________________

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SECTION B: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

1. The patient or patient's representative must read the following statements and sign where indicated:
   a. I understand that my heath care and the payment for my health care will not be affected if I do not sign this form
   b. I understand that I may see and copy the information on this form if I ask for it, and that I get a copy of this form after I sign it.
2. I understand that this authorization will expire on ____/____/____. (In any event this consent expires 90 days after it is signed.)
3. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

____ Date____________________

Signature of patient or patient's representative
(Form must be completed before signing)

If the authorizing signature is not that of the patient, indicate the legal relationship to the patient and legal basis on which consent is given for the patient____

____ Date____________________

Witness Signature

SECTION C: REVOCATION OF RELEASE

MUST BE COMPLETED WHEN REVOKING PREVIOUS RELEASE OF AUTHORIZATION

I hereby revoke the authorization for release of information previously signed on ________________.
I understand that the practice may have made disclosures based on my previous authorization and that this revocation does not affect those disclosures.

____ Date____________________

Signature of patient or patient's representative

If the authorizing signature is not that of the patient, indicate the legal relationship to the patient and legal basis on which consent is given for the patient____

____ Date____________________

Witness Signature