Allergy & 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 the information:

____
____
____
____
____
____

Persons/organizations receiving the 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
8888 Ladue Road, Ste 105
St. Louis, MO 63124
Phone: 314-725-8844
Fax: 314-725-8846

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 ______________

SECTION B: Must be completed for all authorizations

1. The patient or the patient's representative must read the following statements and sign where indicated:

   a. I understand that my health 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 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