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|---|--|---|-------------|
| <b>ALLERGY A.R.T.S.</b><br><b>6842 Plum Creek</b><br><b>Amarillo, Texas 790124</b><br><b>Phone 806-353-7000 * Fax 806-356-1147</b>  |  |   |             |
| <b>AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION</b>  |  |   |             |
| Patient Name _____  |  | Daytime Telephone Number _____  |             |
| Birth Date _____  | SS # _____   | Treatment Dates<br>From: _____ To: _____  |             |
| <b>INFORMATION REQUIRED</b>   |  | <b>REASON FOR REQUEST</b>   |             |
| Diagnostic Tests<br><input type="checkbox"/> Radiology Reports<br><input type="checkbox"/> Lab Reports<br><input type="checkbox"/> Pathology Reports<br>Other (specify):<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ | <input type="checkbox"/> History & Physical<br><input type="checkbox"/> Consultation<br><input type="checkbox"/> Operative Reports<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Entire Record<br><input type="checkbox"/> Statements of charges/pmts<br><input type="checkbox"/> Other (specify):<br>_____<br>_____<br>_____<br>_____<br>_____ | <input type="checkbox"/> Continued Treatment<br><input type="checkbox"/> Insurances<br><input type="checkbox"/> Patient's Personal Record<br><input type="checkbox"/> Legal<br><input type="checkbox"/> Other (specify):<br>_____<br>_____<br>_____<br>_____<br>_____ |             |
| <b>INFORMATION TO BE RELEASED TO:</b>   |  | <b>INFORMATION TO BE RELEASED FROM:</b>   |             |
|   |  | <b>Allergy A.R.T.S.</b>   |             |
| Name (Facility, Agency, Physician, etc.) _____  |  | Name (Facility, Agency, Physician, etc.) _____  |             |
|   |  | <b>6842 Plum Creek</b>  |             |
| Address _____   |  | Address _____   |             |
|   |  | <b>Amarillo Texas 79124</b>   |             |
| City _____  | State _____  | City _____  | State _____ |
|   | Zip _____  |   | Zip _____   |

I understand that this Authorization to Release Protected Health Information specifically includes any and all records, regarding testing, diagnosis, evaluation, or treatment for mental or emotional conditions, alcoholism, drug addiction, HIV infection or AIDS. Any and all records, whether oral or in electronic format, are confidential and cannot be discussed without my prior written authorization, except as otherwise protected by law.

I understand that **Allergy A.R.T.S.** will not condition treatment or other benefits on my signing this Authorization. I understand that once information is disclosed under this Authorization to someone who is not a healthcare provider, the information may no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I also understand that I have the right to revoke this Authorization at any time, except to the extent that **Allergy A.R.T.S.** has taken action in reliance on the Authorization, by delivering or sending written notice of revocation to **Allergy A.R.T.S.** at the address above. If I do not revoke this Authorization, it will expire in sixty (60) days.

With this knowledge, I give my consent to \_\_\_ release or \_\_\_ obtain the protected health information as specified above and release the organization, its authorized employees and agents from any liability in connection with the release of the specified information and pursuant to this signed Authorization to Release Protected Health Information.

A copy of this release has the same force and effect as an original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Authorized to Consent for Patient

\_\_\_\_\_  
Name & Relationship (if signed by anyone other than patient [parent, legal guardian, personal representative, etc.]

\_\_\_\_\_  
Reason patient is unable to sign

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date