ALLERGY & ASTHMA ASSOCIATES-SOUTH

33 Cohasset Avenue, Unit #2 iplomates of the American Board of Allergy & Immunology 40 Tremont Street, Suite #52
Buzzards Bay, MA 02532 Duxbury, MA 02332
Tel: (508) 759-7555 Tel: (781) 934-6200
Fax: (508) 759-7355 Fax: (781) 934-9118

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
TO ALLERGY & ASTHMA ASSOCIATES (John Costa, MD, Lakiea Wright, MD, Monica Ghoshhajra, MD)

1. I hereby authorize _____

   _____
   to disclose the following health information from the medical records of the patient listed below. I understand that information disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient name:** _____Date of birth: _____/_____/_____

   Address:_____
   Street City State Zip

3: **Information to be disclosed to (check one):**

□ **Allergy & Asthma Associates-South 33 Cohasset Avenue, Unit #2 Buzzards Bay, MA 02532 Fax #508-759-7355**
□ **Allergy & Asthma Associates-South 40 Tremont Street, Suite 52 Duxbury, MA 02332 Fax #617-934-9118**

4. **Disclose the following information for treatment dates:**_____to_____

__Complete Records	__Consult	__Physical Therapy
__Discharge Summary	__X-Ray	__Emergency Reports
__History & Physical	__Laboratory	__Other (specify)_____
__Outpatient Records	__Pathology	_____

5. The above information is disclosed for the following purposes:
   __Medical Care __Legal __Insurance __Personal

6. I understand I may revoke this authorization at any time by requesting such of the above-referenced Hospital/physician/facility in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization expires after ninety (90) days from the date I signed it unless otherwise specified.

7. _____ 8._____
   Signature of patient or legal representative **Date**

9. _____ 10._____
   Printed name of patient or patient's representative **Relationship to patient or authority to act for patient (attach documentation)**

11. I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or other sensitive information. I agree to its release unless otherwise specified (please explain).
    _____

12._____ 13._____
   Signature of Patient or Legal Representative **Date**

14._____ 15._____
   Printed name of patient or patient's representative **Relationship to patient or authority to act for Patient (attach documentation)**