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AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

TO WHOM IS THIS FORM BEING SENT ? (name/address) _____

I hereby authorize the use or disclosure of individually identifiable health information as described below:
WHOSE INFORMATION IS REQUESTED ?

PATIENT NAME: _____ BIRTHDATE: _____ CHART # _____
(PRINT) If name was different due to marital status then include previous name

WHO IS MAKING THE REQUEST ?

The name of the person (or entity) authorized to make this request: _____
PRINT the name of the person, the entity, or category of persons/entities authorized to make this request)
Relationship to patient of the person (entity) making the request _____
OR what is the authority of this individual or entity to make the request? _____

TO WHOM OR WHAT ENTITY IS THE PRIVATE HEALTH INFORMATION TO BE DISCLOSED ?

DR. ANDREW GREEN & DR. RITA SLOAN OR: NAME: _____
3615 SENECA STREET ADDRESS _____
WEST SENECA, NY 14224-3461 _____
716-675-2660 FAX: 716-675-2663 _____
PHONE: _____ FAX _____

WHAT INFORMATION IS REQUESTED ? Specifically describe the information to be used or disclosed, including, but not limited to specific detail such as date of service, type of service provided, level of detail to be released. This office will **NOT** respond to a request that simply says "All records".

WHY IS THIS INFORMATION BEING REQUESTED ? List the reason the protected health information is requested. If the individual elects not to provide a statement of purpose then state "at the request of the individual".

EXPIRATION DATE OF THIS AUTHORIZATION: _____ Such date cannot be greater than 90 days from the date of the request. If no date is given then this authorization will expire 90 days after the signature date below.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the practice named in the letterhead above. I understand that a revocation is not effective to the extent that such medical practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself. I also understand that such medical practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and the consequences of me refusing to sign this authorization. I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal or state law.

I have received a copy of this authorization, if requested.

Signature of Patient or Personal Representative _____ Date: _____
Print Name _____