ALLERGY & ASTHMA CARE
OF SAINT LOUIS

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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: _____ Account Number: _____

Patient Date of Birth: _____ Patient SSN: _____

Our office will be ☐ Providing records ☐ Receiving records	The facility below will be ☐ Providing records ☐ Receiving records
Allergy & Asthma Care of Saint Louis Michele E. Kemp, M.D. Stephanie S. Park, M.D. Douglas R. Berson, M.D. ☐ **Chesterfield Office** 1585 Woodlake Dr., Ste. 201 Chesterfield, MO 63017 Phone: 314-878-2788 **Fax: 314-878-8988** ☐ **Ladue Office** 8888 Ladue Rd., Ste. 105 St. Louis, MO 63124 Phone: 314-725-8844 **Fax: 314-725-8846**	Name of Hospital/Clinic/Person: _____ Address: _____ _____ Phone: _____ Fax: _____

Specific description of information to be used or disclosed: _____
_____
_____

Sensitive information will not be released unless specifically authorized below:

☐ 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 _____.

1. The patient or patient's legal 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 am entitled to receive a copy of this authorization.
2. I understand that this authorization will expire 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.

_____ _____
Signature of patient or patient's representative Date

_____
If 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.