## OCEAN ALLERGY ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

## **HIPAA RELEASE FORM**

NAME:		DATE OF BIRTH/
	RELEASE OF INF	FORMATION
I authorize the records rendered to me		ng claims information, diagnosis, and examination
The information	n may be release to:	
Spouse		
Children		
	OT to be released to anyone.	
mormation is two	or to be released to unyone.	
The release of Informat	ion will remain in effect until te	arminated by mo in writing
_		formation to me in the following manner:
Home #	Cell #	Other
If you are unable to rea	ach me:	
You may leave a	detailed message.	
Please leave a m	essage asking me to return you	ır call.
l,	(Patient/Pare	ent of minor child), acknowledge that I have
received a copy of Ocea	in Allergy Partners LLC's notice	ent of minor child), acknowledge that I have regarding Privacy of Personal Health Information.
Signed		Date: