OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

HIPAA RELEASE FORM

NAME: _____ DATE OF BIRTH ____/____/_____

RELEASE OF INFORMATION

_____I authorize the release of information including claims information, diagnosis, and examination records rendered to me.

The information may be release to:

Spouse_____

Children _____

Parent _____

Other _____

_____ Information is NOT to be released to anyone.

The release of Information will remain in effect until terminated by me in writing.

I further agree that the practice may disclose health information to me in the following manner:

Home # _____ Cell # _____ Other_____

If you are unable to reach me:

_____ You may leave a detailed message.

_____ Please leave a message asking me to return your call.

I, _____(Patient/Parent of minor child), acknowledge that I have received a copy of Ocean Allergy Partners LLC's notice regarding Privacy of Personal Health Information.

Signed _____ Date: _____