Allergy & Asthma Associates

Dr. Douglas Barstow & Dr. Thomas Leath

Authorization to Release Protected Health Information to Family and Friends

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals (family and friends):

1 _____

2 _____

3 _____

4 _____

5 _____

Please check all boxes that apply. THE PRACTICE STAFF HAVE MY PERMISSION TO LEAVE MESSAGED CONCERNING TREATMENT (i.e. lab results, prescription refills, etc.). ON MY:

- ❑ Home Answering Machine/Voicemail — Home Phone: _____
- ❑ Cell Phone Voicemail — Cell Number: _____
- ❑ Work Voicemail — Work Number: _____
- ❑ NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided.)

_____ Print Name of Patient

_____ Print Name of Authorized Representative*

_____ Patient/Authorized Representative Signature

_____ Date Signed

*Authorized Representative's authority to act on the patient's behalf:

❑ Parent/Legal Guardian ❑ Power of Attorney

*Evidence of authority must be provided and on file with the practice.