ALLERGY, ASTHMA AND SINUS CENTER, P.C.
800 E. Cheves Street, Ste. 420
Florence, SC 29506
843-679-9335 (office) 843-679-9294 (fax)

www.allergysc.com

Patient Information: I give permission to release the health information of: _____ **(One Patient Per Form)**

Patient Name:_____ Date of Birth:_____

Street Address:_____ Last 4 numbers of SSN:_____

City, State, Zip:_____ Telephone: ( ) _____

Email Address:_____

Release Information From: _____ ***Release Information To:*** _____

(List applicable Facility(s) and/or Practice(s)) (Name of facility, person, company)

(Street Address or PO Box, City, State, Zip Code)

(Phone number) (Fax number) (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): / / Request of individual/person / / Continued Patient Care / / Insurance
/ / Legal purpose including discussions and proceedings / / Other

Fill in dates of treatment for records to be released: ***Treatment dates***: From _____ To _____

Facility Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies, Office/Clinical Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Facility (check all that may apply :)

Office/Clinic/Home Care
/ / Office/Clinical Summary
/ / Office/Home Visits
/ / Physical Exam
/ / Laboratory Reports
/ / Radiology Reports
/ / Other: _____

FORMAT:
/ / Fax / / Paper Copy / / Other _____

DELIVERY METHOD:
/ / Reg. US Mail / / Pick-Up / / Fax, where permitted
/ / Overnight/Express Mail Service, where permitted
/ / Other: _____

PATIENT RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any Cancellation will apply only to information not yet released by facility or practice.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- AASC will not share or use my health information without my permission other than by ways listed in AASC's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at Allergy, Asthma and Sinus Center, P.C.
- A fee may be charged for providing the protected health information.

This permission expires two year after the date of my signature unless another date or event is written here: _____

Signature:_____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form: Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

/ / Healthcare Agent/POA / / Guardian / / Executor/Administrator/Attorney in Fact / / Spouse
/ / Parent / / Adult Child / / Affidavit Next of Kin / / Other:_____

Signature of Minor: _____ Print Name:_____ Date:_____

Authorization given to patient / Date of release:_____ ***via / / Mail / / Fax / / Other***_____ ***/ / ID Verified / / DL/Other ID***_____
Employee Name:_____ ***Date:***_____