AIANE Allergy & Immunology Associates of New England

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR PERSONAL REPRESENTATIVES

I _____, hereby authorize Allergy and Immunology Associates of New
(name of patient)
England, LLC. to share confidential information to the following:

☐ Physician / or nursing staff of : _____
(other than your Primary Care Physician)

☐ Business Services

☐ Other _____
(Example: patient's school, patient's daycare)

_____
(name, phone & relationship to patient)

_____
(name, phone & relationship to patient)

_____
(name, phone & relationship to patient)

concerning:

☐ All matters relating to my health care including mental health, alcohol & drug treatment, and communicable diseases; or

☐ Only my health care problems and treatment relating to: _____

_____

(describe the conditions for which information may be released)

☐ **I do not wish to release my medical records without written consent.**

I understand there is no expiration date on this release. This authorization may be revoked at any time by notifying Allergy and Immunology Associates of New England, LLC in writing, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to Allergy and Immunology Associates of New England, LLC.

I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations.

_____ _____
Patient/Guardian Signature Today's Date

Release of Personal Health Information to Family Members or Personal Representatives