

Authorization to Release Protected Health Information (PHI)

The William Storms Allergy Clinic
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LAST NAME	FIRST NAME	MIDDLE	MAIDEN/OTHER	TELEPHONE
ADDRESS			CITY	STATE ZIP
			DATE OF BIRTH	

I authorize and give my permission for:

To release information to:

Organization/Individual _____

Street Address _____

City _____ State _____ Zip _____

Organization/Individual _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ FAX _____

Information to be released: ** Date of Service _____

Phone _____ FAX _____

Date of Service _____

- Allergy skin testing _____
- Lab Reports _____
- CT Disk or Report _____
- Progress Notes _____
- ALL RECORDS** _____

- Immunization Records _____
- Workman's Comp Records _____
- Other _____

The disclosure is being made for the following purpose(s): **

- | | | |
|--|---|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Physician Dissatisfaction | <input type="checkbox"/> Relocation/Moving |
| <input type="checkbox"/> Staff Dissatisfaction | <input type="checkbox"/> Attorney/ Court Case | <input type="checkbox"/> Workman's Comp |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Insurance / Billing Difficulties | <input type="checkbox"/> Other (comments) _____ |
| <input type="checkbox"/> Changing Physicians (explain) _____ | <input type="checkbox"/> Insurance Change (specify name or New Company) _____ | |

I understand that if the person(s) and/or organizations listed above are not health care providers, health plans, or health care clearing houses, who must follow the federal privacy standards, the health information disclosed is a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

I understand that a copy shall be considered as valid as the original. I may inspect and arrange for copies of the information that is to be disclosed with the Health Information Management department. I understand that I have a right to revoke this authorization at any time by providing written notice to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company as needed to contest a claim under my policy.

I understand that authorizing this disclosure of this medical information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits with the organizations/persons listed above. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I fully understand that my PHI relating to the above records being released may include reference to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, and/or HIV test results/acquired immune deficiency syndrome.

Unless otherwise revoked, this authorization will **expire 60 days from the date signed.**

****Records will be available 5 business days from date of request. ****

****Rush fee of \$25.00 will be assessed if needed sooner. ****

Signature of Patient or Legal Representative (If Legal Rep., state relationship to patient) _____

Date Signed _____

Time Signed _____

Signature of Witness (only required when patient cannot sign) _____

Date Signed _____

Time Signed _____

Office Use Only

Date Needed By: _____
Info Released By: _____

Records to be: Mailed Faxed Picked Up
Time Picked Up: _____

Date Completed: _____
Verified SSN Other ID-Photo
 Drivers License #