Authorization to Release
Protected Health Information (PHI)

The William Storms Allergy Clinic
1625 Medical Center Point, #190
Colorado Springs, CO 80907
Tel. (719) 955-6000
Fax (719) 955-9595

William W. Storms, M.D.

Julia G. Mesnikoff, FNP-BC
Kori Schulte, FNP-BC, AE-C
Kathryn Blair, PhD FNP-BC
Carol Halle, FNP-BC, AE-C
Kelly G. Eskew, FNP-BC

____
LAST NAME FIRST NAME MIDDLE MAIDEN/OTHER TELEPHONE

____ ___/___/___
ADDRESS CITY STATE ZIP DATE OF BIRTH

I authorize and give my permission for:

____
Organization/Individual

____
Street Address

____
City State Zip

____
Phone FAX

To release information to:

____
Organization/Individual

____
Street Address

____
City State Zip

____
Phone FAX

Information to be released: ** Date of Service Date of Service

- ❑Allergy skin testing ______________
- ❑Lab Reports ______________
- ❑ CT Disk or Report ______________
- ❑Progress Notes ______________
- ❑Immunization Records ______________
- ❑Workman's Comp Records ______________
- ❑ Other ______________
- ❑**ALL RECORDS** ______________

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

- ❑Further Medical Care
- ❑Staff Dissatisfaction
- ❑Personal Use
- ❑Changing Physicians (explain) ______________
- ❑Physician Dissatisfaction
- ❑Attorney/ Court Case
- ❑Insurance / Billing Difficulties
- ❑Insurance Change (specify name or New Company) ______________
- ❑Relocation/Moving
- ❑Workman's Comp
- ❑Other (comments) ______________

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: ______________ Records to be: ❑Mailed ❑Faxed ❑Picked Up Date Completed: ______________
Info Released By: ______________ Time Picked Up: ______________ Verified ❑ SSN ❑Other ID-Photo ❑ Drivers License #