ALLERGY A.R.T.S.
6842 Plum Creek
Amarillo, Texas 790124
Phone 806-353-7000 * Fax 806-353-8726

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name		Daytime Telephone Number
Birth Date	SS #	Treatment Dates From: To:

INFORMATION REQUIRED		REASON FOR REQUEST
Diagnostic Tests ❑ Radiology Reports ❑ Lab Reports ❑ Pathology Reports Other (specify): ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	❑ History & Physical ❑ Consultation ❑ Operative Reports ❑ Progress Notes ❑ Entire Record ❑ Statements of charges/pmts ❑ Other (specify): ______________________ ______________________ ______________________ ______________________ ______________________	❑ Continued Treatment ❑ Insurances ❑ Patient's Personal Record ❑ Legal ❑ Other (specify): ___________________ ___________________ ___________________ ___________________ ___________________ ___________________ ___________________ ___________________

INFORMATION TO BE RELEASED TO:	INFORMATION TO BE RELEASED FROM:
Name (Facility, Agency, Physician, etc.) ALLERGY ARTS LLP	Name (Facility, Agency, Physician, etc.)
Address **6842 Plum Creek Dr.**	Address
City State Zip **Amarillo Texas 79124**	City State Zip

I understand that this Authorization to Release Protected Health Information specifically includes any and all records, regarding testing, diagnosis, evaluation, or treatment for mental or emotional conditions, alcoholism, drug addiction, HIV infection or AIDS. Any and all records, whether oral or in electronic format, are confidential and cannot be discussed without my prior written authorization, except as otherwise protected by law.

I understand that **Allergy A.R.T.S.** will not condition treatment or other benefits on my signing this Authorization. I understand that once information is disclosed under this Authorization to someone who is nor a healthcare provider, the information may no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I also understand that I have the right to revoke this Authorization at any time, except to the extent that **Allergy A.R.T.S.** has taken action in reliance on the Authorization, by delivering or sending written notice of revocation to **Allergy A.R.T.S.** at the address above. If I do not revoke this Authorization, it will expire in sixty (60) days.

With this knowledge, I give my consent to ____ **release or** ____ **obtain** the protected health information as specified above and release the organization, its authorized employees and agents from any liability in connection with the release of the specified information and pursuant to this signed Authorization to Release Protected Health Information.

A copy of this release has the same force and effect as an original.

____
Signature of Patient

____
Date

____
Signature of Person Authorized to Consent for Patient

____
Name & Relationship (if signed by anyone other than patient [parent, legal guardian, personal representative, etc.])

Reason patient is unable to sign____________
____
____

Witness ______________________________________
Date ____

ALLERGY ARTS EMPLOYEE RECEIVING REQUEST:
Name ____
Date ________________________