LAWRENCE J. NEWMAN, M.D. ♦ STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

STANDARD AUTORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used/disclosed: Any chart information regarding allergies and/or asthma
Persons Authorized to use/disclose information: Staff of Allergy and Asthma Associates, Inc.

Persons/Organizations/Schools to whom information may be disclosed:

Name	Effective Until

Expiration Date of Authorization and Right to Terminate or Revoke Authorization:
This authorization is effective through the listed effective until date unless otherwise revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Allergy & Asthma Associates, Inc. Attn: Compliance Officer

Potential for Re-Disclosure:
Information disclosed under this authorization may be disclosed again by the organization or person to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Communication:
It is frequently necessary for personnel at this practice to communicate information regarding lab results, instructions, treatment, payment and other items of protected health information with our patients. In the event that we are not able to speak with you (the patient) directly, with whom may we communicate?

Name	Relationship to Patient	Phone

May we leave messages for you on your voicemail (circle appropriate answer and write phone number):
At Home? Yes No @ _____ On Cellular? Yes No @ _____
At Work? Yes No @ _____ By Email? Yes No @ _____

In case of emergency while you are in our care, whom should we contact?

Name	Relationship to Patient	Phone 1	Phone 2

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time.

_____
Name of Patient Date

X_____
Signature of Patient or Patient Representative Relationship to Patient