# Authorization for the Use and Disclosure of Protected Health Information

Patient Name: _____ Date of birth: _____

Address: _____ Phone #: _____

City: _____ State: _____ ZIP: _____

I hereby authorize, _____ to disclose my individually
(facility or covered entity)

identifiable health information as described in this authorization to:

**Acadiana Allergy, Asthma & Immunology Center**
**300 Rue Beauregard, Ste. F** **337-484-1414**
**Lafayette, LA 70508** **Fax: 337-233-3188**

Purpose of the disclosure: _____

_____

Specific description and time period of information to be disclosed: _____

_____

_____ I acknowledge, and hereby consent to, the release of protected health information regarding:
(initials) ____ alcohol abuse/treatment _____drug abuse/treatment
____ psychiatric treatment/mental illness ____ HIV/AIDS infection/treatment
____ sexually transmitted diseases/treatment ____ genetic testing

- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect payment for or coverage of services, or ability to obtain treatment.
- I understand that Louisiana law and regulations allow for fees/charges to be applied to this release of information.
- I understand that I may inspect or copy the information used or disclosed upon request.
- I understand that I may revoke this authorization at any time by notifying Dr. Pratt's office in writing, except to the extent that:
    a. action has been taken in reliance on the authorization
    b. if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself
- I understand that I have a right to request and receive a Notice of Privacy practices from Dr. Pratt's office upon request.
- I understand that I may receive a copy of this authorization upon request.
- I understand this release does not authorize verbal communications by Dr. Pratt's office to the requesting party.
- The person/organization authorized to use/disclose the information will receive compensation for doing so.

____ Yes ____ No

This authorization will expire on: Date: _____

**I have read the above and authorize the disclosure of the protected health information as stated.**

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Print name of the Patient/Legal Representative Relationship to Patient