

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____ Physician: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Account Number: _____

I hereby authorize AllerVie Health to use, disclose and/or obtain my health information as follows (*check all that apply*):

- ☐
- Use**
- the following health information maintained by AllerVie Health until (
- if no date this release will expire after 1 year*
-):

Date: _____

- ☐
- Disclose**
- health information to: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____

- ☐
- Obtain**
- health information from: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc*):
_____This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*):

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is **voluntary**. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying AllerVie Health in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.

Signature of Patient or Patient's Representative Printed Name of Patient's Representative (*if applicable*) DateRepresentative's Relationship to Patient (*if applicable*): _____

Please list AllerVie location(s) that you receive healthcare from:

Name of Location: _____

Address: _____ City, State, ZIP: _____

Please send all record requests to your local AllerVie Health location. To find the location nearest you, please visit **allervie.com**.