PEACHTREE ALLERGY AND ASTHMA CLINIC, P.C.

1800 Peachtree St. NW, Suite 720
Atlanta, GA 30309
404-351-7520

2675 Paces Ferry Rd. NW, Suite 160
Atlanta, GA 30339
678-305-9871

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Peachtree Allergy and Asthma Clinic to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Peachtree Allergy and Asthma Clinic to use or disclose to:

____

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

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This authorization will expire on ____
(Expiration Date or Defined Event)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Peachtree Allergy and Asthma Clinic has acted in reliance upon this authorization. My written revocation must be submitted to Peachtree Allergy and Asthma Clinic's Privacy Officer at: 1800 Peachtree St. NW; Suite 720; Atlanta, GA, 30309.

Print Name of Patient: ______________________________ Date of Birth: _____________

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________
Print Name of Person Signing Document Date