348 East Virginia Ave., Phoenix, AZ 85004 (480)897-6992 Fax (602)274-5225
705 South Dobson Rd., Chandler, AZ 85224 (480)897-6992 Fax (480)752-1757
4852 East Baseline Rd., #101 Mesa, AZ 85206 (480)897-6992 Fax (480)346-4685
8140 East Cactus Rd., #710 Scottsdale, AZ 85260 (480)897-6992 Fax (480)344-4465
21321 East Ocotillo Rd., #128 Queen Creek, AZ 85142 (480)897-6992 Fax (480)839-1874

Standard Authorization of Use and Disclosure of Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name_____ Date of birth_____

Information to Be Used or Disclosed

The information covered by this authorization includes:

_____

_____

_____

_____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

_____

_____

_____

_____

Persons Authorized to Use or Disclose Information (Who is sending information)

Information listed above will be used or disclosed by:

_____

_____Name of person/organization

_____

_____Address/Phone/Fax

Persons to Whom Information May Be Disclosed (Who is receiving information)

Information described above may be disclosed to:

_____

_____Name of person/organization

_____

_____Address/Phone/Fax

Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Arizona Allergy Associates.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Arizona Allergy Associates discloses it to another party.

Sensitive information

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse. **Patient/Representative Initials _____**

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization.
You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, Arizona Allergy Associates will not deny you any treatment except research-related treatment.

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

_____