AAAM
Allergy & Asthma Associates of Maine

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I understand that completion of this form means that I am giving permission for the use and disclosure described below.

Please carefully review and complete this form. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I hereby authorize:

Allergy and Asthma Associates of Maine, 195 Fore River Parkway, Suite 410, Portland, Maine 04102

Tel: 207-774-9839 Fax: 207-761-2127

To disclose to:

Name of Recipient **Address**

Records and information pertaining to:

Name of Patient_____

Date of Birth _____ Phone Number _____

Address _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.

REVOCATION: This Authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon Authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A fee of $5 for the first page and $.45 for each additional page, up to a maximum of $250 for the entire treatment record of medical report. This must be paid before delivery of medical records to Self/Other.

Check the box and initial to specify which type of information is to be disclosed. _____initials

□ Complete Medical Records □ Reports and Test Results □ Medication □Labs & X-Ray's □ Other:

The recipient may use the health information authorized on this form from the following:

_____

Date: _____ Signature: _____

If signed by other than patient, indicate relationship: _____