ASTHMA & ALLERGY SPECIALISTS, PA

C. Thomas Humphries, MD, MBA
Hugh R. Black, II, MD
William S. Ashe, Jr., MD
Sary L. De La Rosa, MSN, FNP-C

Ph: (704) 341-9600 • Fax: (704) 341-9996

8045 Providence Rd.
Suite 300
Charlotte, NC 28277

10310 Mallard Creek Rd.
Suite 101A
Charlotte, NC 28262

13557 Steelecroft Pkwy
Suite 2200
Charlotte, NC 28278

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

☐ I would like my records to be transferred to Asthma & Allergy Specialists from the below listed provider (*See below for specific request) ***Please fax records to (704) 341-9996

☐ Asthma & Allergy Specialists may release my Health Information the provider listed below *(see below for specific request)*

INFORMATION TO BE RELEASED (check all that apply):

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ X-Rays

Entity or person from whom information is being requested/Entity or person receiving information from Asthma & Allergy Specialists:

Name: _____

Address: _____

Phone _____ Fax: _____

☐ **Send the information electronically. Email address: _____**

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____Date:_____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____ _____:_____ AM/PM
DATE Time

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file