Esse Health / Gateway Asthma & Allergy Relief
Authorization for Release of Medical Information

Patient Name (print)_____ DOB:_____/_____/_____

Social Security Number _____-_____-_____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
   Name _____
   Address _____
   Phone _____ Fax _____

3. The type and amount of information to be used or disclosed is as follows:
   - ☐ Allergy Skin Testing
   - ☐ Contents of Allergy Extract
   - ☐ X-ray Reports
   - ☐ Laboratory Reports
   - ☐ Other (please specify) _____

   Dates of Treatment _____

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care, and treatment will not be released to this office: Alcohol Abuse, Mental Health Notes, Drug and Substance Abuse, or Testing for presence of HIV-Antibodies and/or treatment of AIDS.

5. This information may be released to and used by the following individual or organization:
   Name _____
   Address _____
   Phone _____Fax _____
   For the purpose of _____

6. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization | must do so in writing. must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office.

_____ _____
SIGNATURE of patient or legal representative Date

_____
PRINT NAME of patient or legal representative (specify relationship to patient)

For Office Use Only

Purpose for Transfer (circle one): Insurance change Relocation Other _____

Date Records Released _____Copied By _____

Physician's Authorization _____