Smell and Taste Clinic - AllergyCorp Group
P: 336-897-3191 F:866-336-5949

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize, Smell and Taste Clinic - AllergyCorp Group disclose the following identified health information.

PATIENT INFORMATION

Name of Patient: _____ Date: _____

Name (if applicable): _____ SSN: _____

Date of Birth: _____ E-mail Address: _____

Address: _____ Phone Number: _____

City, State, Zip Code: _____

RELEASE INFORMATION FROM

Care Provider: Smell and Taste Clinic - AllergyCorp Group

INFORMATION TO BE RELEASED

Dates of Treatment Requested: _____

I understand that the Protected Health Information in my medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Information to release:

- ☐ All Records
- ☐ Office Visit Notes
- ☐ Prescriptions
- ☐ History & Physical
- ☐ Labs
- ☐ Consultation Report(s)
- ☐ Discharge Summary(s)
- ☐ Test & X-ray Reports
- ☐ Operative Report(s)
- ☐ Therapy Note(s)
- ☐ MRI / X-ray images
- ☐ Itemized Billing
- ☐ MRI / X-ray on CD
- ☐ Other _____

Limitations: Do not release information in my records regarding:

RELEASE INFORMATION TO (if not patient)

Name:

Address: _____ E-mail Address: _____

City, State, Zip Code: _____ Phone Number: _____

Purpose for disclosure:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification attention to: Smell and Taste Clinic - AllergyCorp Group, 5409 W Friendly Ave, Greensboro, NC 27410. I understand that this authorization will expire in sixty, (60) days unless otherwise specified. ***Expiration Date (if not sixty days)** _____.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all fees associated with releasing my health information. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

Signature of Patient: _____ Date: _____

Relationship to patient if other than patient _____

Witness: _____ Date: _____