KELLY S. BRAUER MD, FACAAI

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider; the released information may no longer be protected by federal privacy regulations.

Patient name: ____

First Middle/Maiden Last

Address: ____

Street City State Zip

Social Security #: _______________________ Date of Birth: _________________________

Information to be released FROM:

Facility Name: _________________________

Address: ______________________________

Phone: ________________________________

Fax: _________________________________

Information to be released TO:

Bluegrass Family Allergy, PLLC

2200 E. Parrish Ave, Building A

Owensboro, KY 42303

Ph: 270-228-2811 F: 270-228-2812

Dates of services being requested: From __________________ to ____________________

Check the specific information to be released:

___ Breathing tests

___ Laboratory/Radiology reports

___ Office Notes

___ Skin Tests/Results

___ Other (specify) __________________________

Purpose of disclosure:

___ Insurance

___ Legal Review

___ Medical Review

___ Other

The named entity is authorized to (select both if applicable): ___ Use protected health information for treatment, payment, and operations

___ Disclose protected health information to entity named

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclosure of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: ____ Date: _____________________

Signature of Patient or Responsible Party: _________________________________