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.

I hereby authorize: _____

Name of Disclosing Party

_____

Complete Address or Fax Number

To disclose to:

Allergy and Asthma Associates of Maine

Attention: Medical Records

195 Fore River Parkway, Suite 410, Portland, Maine 04102

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

Records and information pertaining to:

_____

Name **Date of Birth** **Phone Number**

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

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.

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.

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

□ Allergy Testing □Labs & X-Ray's □ Other: _____Initials.

Specify the records to be disclosed:

The recipient may use the health information authorized for the following:

Date: _____ Signature: _____

If signed by other than the patient, indicate relationship: _____