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### AAIC Record Release Authorization

This form provides authorization to the Allergy, Asthma & Immunology Center, SC (AAIC) to use or disclose your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. Please read and complete this form in its entirety and return to us.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AAIC #:** \_\_\_\_\_

I hereby authorize AAIC, SC to release to/obtain from (circle one):

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip Code:** \_\_\_\_\_

The following information should be released (please specify dates of service, specific information to be released, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose for the information being released is:  
 Specialist Referral  Second Opinion  Transfer of care

Other (please specify): \_\_\_\_\_

This authorization is good for a period of one year from the date signed. I understand that I have the right to revoke this authorization at any time, in writing. I understand that a revocation is not effective to the extent that AAIC, SC has taken action in reliance on this authorization. I understand there is the potential for information released pursuant to this authorization to be re-disclosed by the recipient if the recipient is not required by law to protect the privacy of information.

**Signature of Patient or Personal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Description of Personal Representative's authority:** \_\_\_\_\_