Florida Allergy Clinic
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AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION

The patient-physician relationship is held in strictest confidence. We will NOT discuss anything about your medical condition or care of plan with anyone including parents, spouse or child without your written permission to do so.

[ ] I have received and/or read a copy of the Privacy Policy (HIPAA) _____ (initials).

[ ] I have received and/or read a copy of the Financial Policy _____ (initials).

[ ] I request that FL Allergy Clinic NOT discuss my private health information and care plan with anyone other than myself.

If you want to avail other people of your private health information, please complete the section below indicating to whom you authorize us to release this information.

[ ] I _____, authorize FL Allergy Clinic to speak with the following people on my behalf, regarding my medical condition and/or plan of care:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing my name below I am being made aware that my health information may be communicated in person, by telephone, fax, mail, or e-mail. Sexually transmitted diseases and HIV, drug/alcohol abuse, can only be delivered to the actual patient in person during an office visit.

_____ _____
Print Patient name DOB — Date

_____ _____
Signature of Patient/Legal Representative — Witness Name (office staff)

_____ _____
Relationship of Legal Representative (if applicable) — Witness Signature