Steven Rosenberg, MD ♦ Carlos Jacinto, MD ♦ Harleen Anderson, MD

AUTHORIZATION TO OBTAIN OR DISCLOSE PROTECTED HEALTH INFORMATION "PHI"

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR§164.508]. I authorize Allergy & Asthma Associates of Central Florida, PA ("AAACF"), my physician and/or administrative and clinical staff to:

__ **Obtain** the following protected health information (PHI) detailed below **from**:

Name & Address of entity with the records: _____

_____

or _____

__ **Disclose** the following protected health information **to**:

Name & Address where the records are to be sent: _____

_____

_____

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. AAACF cannot ensure your right to the protection of the privacy of this information once it is disclosed to another party.

Please forward copies of the following:

___ Initial History & Physical
___ Progress Notes
___ Clinical Summary
___ Laboratory Results
___ Spirometry Reports
___ Radiology Reports
___ Skin Test Results
___ Serum Mixture (contents and concentration)
___ Immunotherapy Schedule
___ Other: _____

Please mail or fax records to: (circle one)

Winter Park	**Orlando**	**Altamonte**
1890 S.R. 436 Ste 215	**7232 Sand Lake Rd. Ste100**	**685 Palm Springs Dr, Ste 1E**
Winter Park, FL 32792	**Orlando, FL 32819**	**Altamonte Spr., FL 32701**
fax: 407-678-8154	**fax: 407-370-9715**	**fax: 407-331-6644**

I understand that this consent is revocable upon written notice to Allergy & Asthma Associates of Central Florida (AAACF) except to the extent that action has been taken in reliance on this authorization. This authorization is effective through_____, if no date entered the authorization is in effect until the patient submits a revocation. *(date)*

_____ _____

Signature of Patient/Parent/Guardian *Patient Date of Birth*

_____ _____ _____

Print Name of Patient *Today's Date* *Patient Social Security Number*