Mainland Allergy Clinic

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Main Office
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Dickinson, TX 77539
Phone: 281-337-1512

Bellaire Branch
6550 Mapleridge #217
Houston, TX 77081
Phone: 713-661-9003

Shared Fax: 281-534-1472

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Release my protected health information FROM the following DOCTOR(S)/ENTITY:

Name: _____
Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____
Phone: (_____) _____ -_____ **Fax:** (_____) _____-_____

TO the following person(s)/entity:

Name: MAINLAND ALLERGY CLINIC **Address:** 914 FM 517 WEST
Phone: (281) 337-1512 **Fax:** (281)534-1472 **City:** DICKINSON **State:** TX **Zip Code:**77539

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____
_____

The reasons or purposes for this release of information are as follows:

□ Treatment/Continuing Medical Care
□ School
□ Insurance
□ Disability Determination
□ Employment
□ Billing or Claims
□ Legal Purposes
□ Other *(Specify)*: _____

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

I understand I may revoke this consent at any time. This authorization expires automatically in 90 days.

_____ _____

Patient Name (PRINT) **Date of Birth**

_____ _____

Patient Signature **Date**