REDDING ALLERGY & ASTHMA SPECIALISTS

Patient Name: _____ Birthdate: _____

Contact Phone Number: _____

MEDICAL RECORDS RELEASE

I understand that my protected health information may be requested from any healthcare provider within the past 10 years who may be involved in my health treatment, and that this information may be used to conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below, I permit Redding Allergy and Asthma Specialists to obtain any medical records (including hospital and physician progress notes; radiology and imaging reports; laboratory and pathology reports; and any additional medical data) required for my treatment at RAAC.

Patient/Guardian Signature: _____ Date: _____

It is often helpful if our office sends your office notes, lab results, imaging reports, testing results, etc., to your primary care physician and referral physicians. By signing below, I authorize any and all medical records to be released to my primary care physician and referral physicians. I also authorize Dr. Redding and his nurses to discuss any of my medical conditions with my primary care and referral physicians.

Patient/Guardian Signature: _____ Date: _____

For patients 18 years of age, and older: I hereby authorize you to discuss medical and/or billing information with the following people (please include name and relationship to you): _____

_____ _____

PRIVACY POLICY

Please read the following Privacy Policy and Medical Records Release statements and sign below:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information.

I understand that this protected health information may be used in: coordination of care with other healthcare professionals; healthcare operations such as quality assessments and physician certifications; and health insurance claims processing and reimbursement. I also understand that this organization has the right to change its Notice of Privacy Policy and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Policy.

Patient/Guardian Signature: _____ Date:_____