STAAMP
SOUTH TEXAS
Allergy & Asthma
MEDICAL PROFESSIONALS

Erika G. Gonzalez, MD
Board Certified - Allergy & Immunology

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Board Certified - Allergy & Immunology

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Managing Partner

Authorization to use and Disclosure of Protected Health Information

_____ _____ _____
Print Patient's Name | Date of Birth | Social Security Number

By signing this form, I authorize:

Name: _____

Address: _____

Phone: _____

To release to:

Name: _____

Address: _____

Phone: _____

The following individually identifiable health information about me: (specifically describe the information to be used or disclosed, such as date(s) of services, type of services level of detail to be releases, origin of information, etc.):

☐ All Medical Information ☐ Radiology Reports ☐ Laboratory / Pathology Reports
☐ Progress Notes ☐ Operative Reports ☐ Insurance Information

☐ Other _____

Covering the period(s) of care from _____ to _____.

I understand that information relevant to HIV testing and/or AIDS related diagnosis(es) may be contained in this information. I understand this information may also include reference to psychiatric treatment or treatment for substance abuse.

The information will be used or disclosed for the following purpose(s):

☐ At the request of the individual ☐ Continued treatment ☐ Insurance
☐ Legal ☐ Other _____

This authorization will expire on: _____ not to exceed 24 months.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed under this authorization. South Texas Allergy & Asthma Medical Professionals will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do have to sign this authorization in order to receive treatment from South Texas Allergy & Asthma Medical Professionals. In fact, I have the right to refuse to sign this authorization. When my information is used to disclose pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that South Texas Allergy & Asthma Medical Professionals has acted in reliance upon this authorization. My Written revocation must be submitted to the Privacy Officer at the address above.

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Printed Name of Legal Guardian (if applicable) | Date Signed