ALLERGY ASTHMA
& IMMUNOLOGY ASSOCIATES, LTD

PATIENT DISCLOSURE FORM

I authorize and agree that Allergy, Asthma, & Immunology Associates may disclose my protected health information to the following persons:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Our practice may disclose your PHI to other health care providers involved in your case. Please list the names and addresses of those professionals below.

1._____

2._____

3._____

4._____

I acknowledge and agree that Allergy, Asthma, & Immunology Associates may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Allergy, Asthma, & Immunology Associates.

_____ _____

Print Name of Patient Signature of Patient or Guardian

Date:_____