

ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.
Authorization for Disclosure of Protected Health Information

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) to or for the party or parties below.

What PHI may be used or disclosed?

Describe the purpose for which you authorize AACG use or disclose of PHI:

To whom may the PHI be disclosed?

Entity Name: Allergy & Asthma Clinics of Georgia, PC
Address: 105 Spanish Court
Albany, GA. 31707
Phone Number: 229-438-7100

This authorization will expire on _____. (Expiration date not required)

I understand that when my PHI is disclosed 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 the:

_____ has acted in reliance upon this authorization; or to the extent that the authorization was obtained as a condition of obtaining insurance coverage there is another law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the _____, stating that I wish to revoke this Authorization.

I understand that _____ may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign this authorization.

Patient's Name (please print) _____

If Patient is a Child,
Parent's Name (please print) _____

Signature of Patient (or Parent
if Patient is a Child) _____