



Allergy & Asthma Consultants of Mid-Michigan, P.C.

Ridhu C. Burton, M.D.
Ravinder R. Polasani, M.D.
James H. Saker, M.D.
Clyde R. Flory, M.D.
Diplomates of the American Board
Of Allergy & Clinical Immunology

4169 Legacy Parkway
Lansing, MI 48911
Fax (517) 393-4202
Phone (517) 394-6500
www.lansingallergy.com

PROTECTED HEALTH INFORMATION RECORDS RELEASE FORM

I authorize use or disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth _____

Address: _____ Telephone #: _____

The following individual or organizations are authorized to make the disclosure.

____ Allergy & Asthma Consultants of Mid-Michigan, P.C. to **receive** information from: _____

____ Allergy & Asthma Consultants of Mid-Michigan, P.C. to **send** information to: _____

Itemize records to be copied: _____

There will be a charge of \$_____ for copying records for use other than sending information to another physician.

SENSITIVE INFORMATION: A separate written consent is required to release information regarding HIV/AIDS status or substance abuse unless so ordered by a court.

REDISCLASURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

OTHER RIGHTS: (A) I understand that authoring the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. (B) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ (if I do not specify an expiration date, event, or condition, this authorization will expire in six months).

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to the patient: _____