

**AUTHORIZATION FOR UPDEGRAFF CLINIC FOR ALLERGY & DERMATOLOGY PC
TO USE OR DISCLOSE MY HEALTH INFORMATION**

Patient Name _____ Date of Birth _____
Previous Name:

A. My Authorization

You may disclose the following health care information (check all that apply):

All my health information including, but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, if any, unless specified : _____

My health information relating to the following treatment or condition:

My health information for the date(s):

Other:

You may disclose this health information to:

**Updegraff Clinic of Allergy & Dermatology PC
13000N. 103rd Ave. Suite 50
Sun City, Az. 85351
623-933-3107 Fax
#623-972-1418**

B. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except to take part in a research study, or to receive health care when purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclose of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are, to fill out a revocation available from the office, or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that is this office has requested this authorization, I have a right to receive a copy of it.

Patient or legally authorized signature Date