# ADULT & PEDIATRIC ALLERGY CENTER OF NORTHERN VIRGINIA

100 ELDEN STREET, SUITE 10
HERNDON, VIRGINIA 20170

TELEPHONE: 703-689-2000 FAX: 703-478-6612

Patient's Name: _____

Date of Birth: _____

RELEASE INFORMATION TO:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PURPOSE OF REQUEST: ☐ TRANSFER OF CARE ☐ CONSULTATION ☐ RELOCATION ☐ OTHER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

**I acknowledge and hereby consent to such, that the release of information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____Initial**

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify expiration this authorization will expire in 90 days.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it. I can request a copy of this form after I sign and date it.
6. I understand I will be responsible for the charges incurred in the release of my protected health information.

_____ _____

Signature Date

HIPAA Privacy Authorization Form
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)