



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ date of birth \_\_\_\_\_ authorize Pulmonary & Allergy Associates to furnish to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**The following information (specify type and amount of information requested):**

\_\_\_\_\_  
\_\_\_\_\_

**This information is needed for the following purpose(s):**

\_\_\_\_\_  
\_\_\_\_\_

I understand that if my records contain information identifying me as having been tested for HIV infection, HIV having been identified as the virus which causes acquired immune deficiency syndrome (AIDS), and/or the results of alcohol/drug screening and/or psychiatric or medical records, the results of these tests and such records and information are protected under state law and cannot be disclosed without my written consent or pursuant to a court order.

I have read carefully and understood the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records (including information identifying me as having been tested for HIV and the results of such tests) to those persons/agencies named above.

I release and hold harmless Pulmonary & Allergy Associates and its agents, officers and employees from any liability whatsoever which may result from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law. Please note that the information being released may no longer be protected by federal privacy law.

This authorization is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon 90 days of the date set forth below or (specify event or condition):

\_\_\_\_\_

**Patient/ Guardian Signature:** \_\_\_\_\_

**Patient is unable to sign because:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
*(Signature of Legal Representative)*

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