PARTNERS IN ALLERGY AND ASTHMA CARE, PA - Phone 813.681.6537 / Fax 813.661.3227

Alan B. Halsey, MD Craig A. Kalik, MD Suzan S. Pae, MD Kathryn Convers, MD Kathleen Likar, ARNP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

I request and authorize the release of healthcare information of the patient named above FROM:

Provider/Facility: Name:_____

Address: _____

_____

Fax:_____ Phone:_____

TO THE FOLLOWING FACILITY:

Partners In Allergy & Asthma Care, PA
3658 Lithia Pinecrest Road
Valrico, FL 33596
Fax: 813.661.3227

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: _____ Date Signed: _____

Witness: _____ Date Signed: _____