AGGARWAL ALLERGY & ASTHMA CLINIC

Pediatric and Adult Allergy and Asthma

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Gladstone, MO 64118

JAG AGGARWAL, M.D.

NEELAM AGGARWAL, M.D.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ Date of Birth _____
Print Name of Patient

I hereby authorize AGGARWAL ALLERGY CLINIC, INC., to disclose Individual Identifiable Health Information as described below.

☐ **I authorize the following Person(s) or Organization to RECEIVE Private Health Information FROM AGGARWAL ALLERGY CLINIC.**

DOCTOR'S NAME or Record Recipient: _____ **Phone #** _____

Street Address: _____ **Fax #** _____

City _____ **State** _____ **Zip Code** _____

Expiration: This authorization will expire in 60 days from the date of this authorization unless revoked (in writing) by the Patient prior to that time.

Revocation: I understand that I may revoke this authorization at any time by notifying AGGARWAL ALLERGY CLINIC, INC., in writing. I understand that if I revoke this authorization, it will not affect any action that was taken by AGGARWAL ALLERGY CLINIC, INC., prior to the receipt of my revocation letter.

_____ **Date** _____
Signature of Individual - or Personal Representative/(Requires Identification)

Printed name of Personal Representative: _____. **Rationale for serving as Personal Representative to the Individual. (E.g., parent, legal guardian, etc..) __(Requires Identification)**