

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Denver Allergy and Asthma Associates (DAA) to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on our website [www.denverallergy.com](http://www.denverallergy.com).

Patient authorizes communication with family/friends regarding your **care and test results.**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Patient authorizes communication with family/friends regarding your **account and billing.**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Patient authorizes communication with a primary care physician or other physician (first and last name):**

1. \_\_\_\_\_ M.D.

2. \_\_\_\_\_ M.D.

**Message or responses to inquires:** (If you do not select not allowed, then you authorize DAA to contact you using the following methods)

- May we leave a message on home voicemail? \_\_\_ Not allowed
- May we leave a message with whomever answers the home phone? \_\_\_ Not allowed
- May we call your work and leave a message with the person who answers the phone? \_\_\_ Not allowed
- May we leave a message on work voicemail? \_\_\_ Not allowed
- May we contact you via Email? Email Address: \_\_\_\_\_ \_\_\_ Not allowed
- May we send out your PHI to a third party system? \_\_\_ Not allowed

The physicians at Denver Allergy & Asthma Associates, P.C., participate with Western States Clinical Research in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us with the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will NOT release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies. \_\_\_ Not allowed

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

\_\_\_\_\_  
Signature of patient (or patient's representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed legal name of patient (or patient's representative)