Allergy & Asthma Center, P.C.
330 S. Garden Way #150
Eugene, OR 97401
541-485-0316

Candice M. Rohr, M.D.
Alice H. Chou, M.D.
Alalia W. Berry, M.D.

330-C NW Elks Dr.
Corvallis, OR 97330
541-754-7170

Authorization for Release of Medical/Health Information to Family Member/Friend

I, _____ _____
(patient name) (date of birth)
authorize Candice M. Rohr, M.D.; Alice H. Chou, M.D.; Alalia W. Berry, M.D. of the Allergy and Asthma Center to use and disclose my medical information described below to the following person(s):

_____ _____
(name) (relationship)

_____ _____
(address) (phone number)

List additional person(s) on back of page.

The health information to be used and disclosed includes the information specifically authorized below, as well as all other information my health records relevant to scheduling, discussion of appointments, referrals, disclosing lab and/or imagining results, and for the purpose of: _____

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
_____ By initialing here, I specifically consent to the disclosure of my mental health information.
_____ By initialing here, I specifically consent to the disclosure of my genetic testing information.
_____ By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

By: _____ _____
(signature of patient or patient's personal representative/relationship) (Date)

Unless revoked in writing, this Authorization expires in (please initial):
(_____) one year (_____) five years (_____) never (_____) other_____

Please note:

1. **Our services are not dependent on the receipt of this signed Authorization.**
2. **You may inspect a copy of the protected health information to be used or disclosed.**
3. **You may refuse to sign this Authorization.**
4. **We must provide you with a copy of the signed Authorization**

You have the right to revoke this Authorization at ay time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization. To revoke this Authorization, please contact our Privacy Officer.