Princeton Allergy & Asthma Associates

HIPAA Disclosure Information of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

This authorization is given by: ____**The Patient** ____**Parent/Guardian** _____
Print Name

The physicians/practice may disclose to:

____**Any medical provider/facility**

____**Spouse** _____
Print name

____**Parent**_____
Print name

____**Children**_____
Print name

____**Other** _____
Print Name

_____
Relationship

This authorization is in force until: (MUST check one)

____It is revoked in writing
____One Year

_____
Signature of Patient or Parent/Guardian

_____
Date

9/14/17