MIDWEST SINUS-ALLERGY SPECIALISTS

James S. Denninghoff, M.D.

3401 Berrywood Drive
Suite 201
Columbia, MO 65201

Direct Office: 573-815-0662
Office Fax: 573-443-1162
Toll Free: 877-307-4687

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I _______________________________, hereby authorize Midwest Sinus-Allergy Specialists to obtain or disclose the specific information described below, only for the purposes and parties also described below.

________________________________	____________	______________
Patient Name	Date of Birth	Social Security #

____________________________	______________	______	_______
Patient Address	City	State	Zip Code

Name and Address of Entity Receiving or Releasing Information:

____
Name of Entity Receiving or Releasing Information

____
Address of Entity Receiving or Releasing Information

Description of Specific Information to be released or obtained:

____	Radiology Reports	____	Diagnostic Reports
____	Pathology Reports	____	Operative Notes
____	History and Physical	____	Physician's Orders
____	Entire Medical Record	____	Allergy Testing Results
____	Billing Statement	____	Other ____________________

Date of Records Requested from ___________ to ___________

This information is being requested for the following purpose(s):

____

____

This authorization shall remain in effect for one year from the data signed below or until
___________________.
(expiration date or event)

I understand that:

1 I may inspect or copy the protected health information to be used or disclosed.
2 I may revoke this authorization in writing by contacting your office at the address listed on this form.
2 Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
3 I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

I, ____________________________________, have read the above information and authorize Midwest Sinus Allergy Specialists to disclose or obtain information to the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge Midwest Sinus Allergy Specialists and will hold Midwest Sinus Allergy Specialists harmless for any release made pursuant to this Authorization.

____ ____________
Signature of Patient or Legal Representative Date

____
Description of Legal Representative's Authority (i.e., guardian, parent, etc)

____ __________________
Witness' Signature Date