Allergy & Asthma
Clinic of East Lansing
V. Cuneyt Kalfa, MD
2045 Asher Court Suite 200, E. Lansing, MI, 48823
Phone: (517) 324-7020 Fax: (517) 324-7021

AUTHORIZATION TO OBTAIN OR DISCLOSE PROTECTED HEALTH INFORMATION "PHI"

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR §164.508]. I authorize **Allergy and Asthma Clinic of East Lansing, PLLC,** my physician and/or administrative and clinical staff to:

__Obtain the following protected health information (PHI) detailed below from:
Name & Address of entity with the records:

_____
_____
_____
Phone: _____ Fax**:** _____

X Disclose the following protected health information to:
Name & Address where the records are to be sent:

Allergy & Asthma Clinic of East Lansing
2045 Asher Court Suite 200
East Lansing, Michigan 48823
Phone: 517-324-7020 Fax: 517-324-7021

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Allergy and Asthma Clinic of East Lansing, PLLC, cannot ensure your right to the protection of the privacy of this information once it is disclosed to another party.

Please forward copies of the following:

__ Initial History & Physical
__ Progress Notes
__ Clinical Summary
__ Laboratory Results
__ Spirometry Reports
__ Radiology Reports
__ Skin Test Results
__ Serum Mixture (contents and concentration)
__ Immunotherapy Schedule
__ Other: _____

I understand that this consent is revocable upon written to Allergy and Asthma Clinic of East Lansing except to the extent that action has been taken in reliance on this authorization. This authorization is effective through _____, if no date entered the authorization is in effect until the patient submits a revocation.

_____ _____
Patient/Parent/Guardian Signature **Today's Date**

_____ _____ _____
Printed Name of Patient **Patient Date of Birth** **Patient Social Security Number**