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Authorization For Release of Medical Information

I hereby authorize **Carl Thornblade, MD to use or disclose the specific information marked to be used or disclosed:**

____ Progress Notes **____ Hospital Notes**

____ X-Ray Reports **____ CT Reports**

____ Pulmonary Reports **____ Lab Reports**

____ Skin Testing results **____ ALL**

Other: _____ From _____ To _____

Information is to be sent to: _____

_____

_____

This authorization shall remain in effect from the date signed below until: _____

I understand that:

- **I may inspect or copy the PHI to be used or disclosed.**
- **I may revoke this authorization in writing by contacting your office at the address above.**
- **Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.**

Patient Name: _____ DOB: _____

Patient Address: _____

_____

_____

Patient Phone: _____

Patient /Parent Signature: _____ DATE: _____