Form 3

PURDUE CENTER FOR HEALTHY LIVING
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize (allergy office name) ____
Located at:
____
____
____

to disclose (give out) the health information specified below from my medical record.

This authorization permits One to One Health to use and/or disclose the following individually identifiable health information about me (specifically described the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc. such as a discharge summary, history and physical, progress and provider notes or entire medical record). The following information will be transferred: Physician Order for Allergy Vials, Visit history, Diagnosis, Dispensing information.

1. Information is to be disclosed to: Person/Agency: CENTER FOR HEALTHY LIVING 1400 WEST STATE STREET, BUILDING B, SUITE C, WEST LAFAYETTE, IN 47907. P: 765-494-0111 F: 765-496-6656
2. The purpose of the disclosure: Administration of Allergy Injections
   If requested by the patient, purpose may be listed as "at the request of the individual."
3. I understand that I have a right to revoke (take back) this authorization (permission) at anytime. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to: One to One Health Privacy Officer 246 E. 11th Street Chattanooga, TN 37402. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
4. If not revoked (take back) before such time, this authorization (permission) will expire three (3) years from the date below unless otherwise noted. Otherwise, this authorization will expire on (date): or defined event.
5. I understand that after the above information is disclosed, it may be re-disclosed (given out again) by the person or agency that received it, and the information may not be protected by federal privacy laws or regulations.
6. I understand that authorizing the use or disclosure of the information identified above is voluntary. Whether or not I sign this form is notrequired for receiving health care treatment, payment, enrollment or eligibility for benefits.
7. One to One Health will not receive payment or other remuneration (anything of value) from a third party in exchange for using or disclosing your health information or protected health information.
8. I have a right to receive a signed copy of this authorization form.

Patient Signature: ____ DOB: ______________

Patient Printed Name: ____________________________________ Date: ______________