McKinney
Allergy and Asthma Center

2251 West Eldorado Parkway
Suite 150
McKinney, TX 75070

(P) 972-548-2797
(F) 972-548-2788
www.mckinney-allergy.com

CONSENT TO SHARE MEDICAL INFORMATION (pg 1)

PATIENT NAME: __________________________________DOB: _________DATE:__________

Please check boxes for ALL that apply:

☐ **I authorize the RELEASE of my medical information including diagnosis, records, examination, allergy serum, and claim(s) to the following:**

- ☐ Spouse____
- ☐ Child(ren)____
- ☐ Parent(s)____
- ☐ Grandparent (s) ____
- ☐ Power of Attorney (need court document)______________________________
- ☐ Other ____

☐ **I authorize the SHARING AND DISCUSSION of my medical information and treatment plan to:**

- ☐ Spouse____
- ☐ Child(ren)____
- ☐ Parent(s)____
- ☐ Grandparent (s) ____
- ☐ Power of Attorney (need court document)______________________________
- ☐ Other ____

I authorize the release of my complete health record with the EXCEPTION of the following:

- ☐ Mental Health Records (excluding psychotherapy notes)
- ☐ Genetic Information (including Genetic Test Results)
- ☐ Drug, alcohol, or Substance Abuse Records
- ☐ HIV/AIDS Test results/Treatment
- ☐ Allergen extracts (serum vials) and Allergy shot records

☐ **My Medical records are NOT to be released to anyone.**

☐ **Additional Notes:** ____

____

-By signing below, I understand that my medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

☐_____________(initial/date)

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CONSENT TO SHARE MEDICAL INFORMATION (pg 2)

-I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

-I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

-I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

-This authorization shall be in force and effect from date of consent until ________________________ at which time this authorization expires.

PATIENT/GUARDIAN SIGNATURE:
____

Printed name of legally authorized representative if applicable:_____________________________________

If representative, specify relationship of individual*: ☐Parent of Minor ☐Guardian ☐Other*_____________

******Please remember to initial and date the bottom of each page*************

Public drive: Front Office: Sharing Med Info