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PATIENT DISCLOSURE FORM

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves: not even to parents of 18 year old patients, grandparents that baby-sit or nannies. For that reason, please list the names of all family members, friends, school nurse, etc. that you give us permission to release information to about you or your child's care. If anyone not listed on this form calls or otherwise asks us for information about you or your child (even for information as basic as when your next appointment is or how to give your child's medication), we will have to refuse to give them that information until we get your expressed permission to do so.

I authorize and agree that San Tan Allergy & Asthma may disclose my Protected Health Information to the following:

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

I acknowledge and agree that San Tan Allergy & Asthma may disclose my Protected Health Information to the persons set forth on this form, unless and until I object to such disclosure, which will be provided in writing to San Tan Allergy & Asthma.

Patient Name: _____ Dob: _____

Date: _____

Signature of Patient/Patient's Personal Representative/Legal Guardian