



BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY  
Treating patients of all ages

Date \_\_\_\_\_

**GARRICK P. HUBBARD, M.D. JENNY V. CASBURN, FNP-C SAMANTHA PLITT, PA-C**

Name \_\_\_\_\_ Male/Female  
Last First Middle Nickname Single/Married  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_ Preference : Home/ Cell

Social Security# \_\_\_\_\_ DOB \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_

If patient is a minor, provide Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

**PRIMARY INSURED PARTY INFORMATION**

Name \_\_\_\_\_ Male Female DOB \_\_\_\_\_  
Last First Middle

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Home Phone# ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_

**SECONDARY INSURED PARTY INFORMATION**

Name \_\_\_\_\_ Male Female DOB \_\_\_\_\_  
Last First Middle

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Home phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone# \_\_\_\_\_

**REFERRED BY**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_



**GARRICK P. HUBBARD, M.D. JENNY V. CASBURN, FNP-C SAMANTHA PLITT, PA-C**

**Limited Patient Authorization for Disclosure of Protected Health Information**

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: \_\_\_\_\_

SSN (last four digits): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Entity Requested to Release Information: Allergy & Asthma Care of IN

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: \_\_\_\_\_ Individual/Entity Name: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- Entire patient record; **or**, check **only** those items of the record to be disclosed:
  - office notes
  - nursing home, home health, hospice, and other physician records
  - lab results, pathology reports
  - record of HIV and communicable disease testing
  - x-rays
  - record of mental health or substance abuse treatment
  - financial history report (previous 3 years only).
  - Only send the following: \_\_\_\_\_

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request       Other (please specify): \_\_\_\_\_

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: \_\_\_\_\_
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

\_\_\_\_\_  
patient or authorized representative signature

\_\_\_\_\_  
date

You have the right to receive a copy of signed authorizations upon request.