ALLERGY & ASTHMA
CONSULTANTS OF MONTANA
MICHAEL C. DICELLO, MD
CINDY FEDDES, FNP

Authorization for use and disclosure of Protected Health Information (PHI)

Patient legal name:_____ DOB:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____

I authorize: Allergy & Asthma Consultants
Address: 2055 N. 22nd Avenue Phone: (406) 582-1111
City: Bozeman State: MT Zip: 59718
Fax: (406) 582-1112

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

Person/Organization:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____
Fax:_____

Purpose: ____ Continuation of care ____ Personal ____Insurance ____Litigation ____Other:_____

Dates of treatment:_____ Date needed:_____

Pertinent PHI Information: ____ Entire record ____ Specific item:_____

ACKNOWLEDGEMENT: I request and authorize the above-names doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that this request acts only as a single time use and my information will only be released to the above-named recipient. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be re-disclosed.

OTHER CONDITIONS: A copy of this authorization with my signature may be used with the same effectiveness as an original. I understand that:

- If I do not sign this authorization, Allergy and Asthma Consultants will still provide treatment and seek payment for services provided.
- Fees/charges will comply with all laws and regulations applicable to release of information.

I authorize:_____ to pick up my Protected Health Information.

Signature of patient/patient representative:_____ Date:_____