

I, \_\_\_\_\_, do hereby authorize a representative from National Allergy, Asthma, and Urticaria Centers of Charleston to speak with the following person(s) regarding my: (please check all that apply)

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Medical Care</i>	<i>Appointments</i>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative(s) authorization to the following information:

I do  I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

I do **NOT** wish for any medical information/appointments be released to any representative on my behalf.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

**This form will be valid until patient rescinds authorization in writing.**