Allergy, Asthma & Immunology Center
OF SOUTHWEST LOUISIANA

320 Settlers Trace Blvd., Lafayette, LA 70508
2903 1st Ave., Lake Charles, LA 70601
Phone: 337-981-9495 Fax: 337-981-7451

Name of Patient: _____

Date of Birth: _____

I hereby grant permission for the Allergy, Asthma & Immunology Center of SWLA to discuss, or release information concerning my medical diagnosis, or information relating to it in my medical records, or any medical information that may be on file as it concerns me including but not limited to billing, benefit inquiries, claims, appeals and complaints to the following individuals in compliance with HIPAA guidelines.

Name: _____ Relationship to Above: _____

Name: _____ Relationship to Above: _____

Name: _____ Relationship to Above: _____

Name: _____ Relationship to Above: _____

Name: _____ Relationship to Above: _____

I understand that I have the right to refuse to sign this and that it will not affect my continuation of care. I further understand that I may revoke this consent in writing at any time.

Patient/Guardian Signature: _____

Witness: _____

Date: _____