PARTNERS IN ALLERGY AND ASTHMA CARE, PA

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who contribute to my care, i.e. consultations and referrals;
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes; and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided the opportunity to review the *"Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- To review the *"Patient Privacy Practices"* prior to acknowledging this consent.
- To restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

RESTRICTIONS: *I request the following restrictions to the use or disclosure of my health information:*

_____

_____

ALLOW: *The following person(s) may receive information about my healthcare:*

_____

MESSAGES OR APPOINTMENT REMINDERS: *If you do not want us to leave a message on your answering machine, or with someone at your home reminding you of an appointment, which may also include sensitive healthcare information, please check the box below:*

❑ DO NOT leave a message on my answering machine or with anyone at my home.

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers, labs, and/or other individuals, or agencies as permitted, or required by state or federal law.

I fully understand the information provided by this Consent. *(Upon your request, a copy of the "Patient Privacy Practices" sheet will be provided.)*

_____	_____	_____
Signature	*Print Name of Person Signing*	*Date*

Note: If other than patient is signing, are you the parent, legal guardian, custodian, or have the Power of Attorney for this patient, for treatment, payment or healthcare operations. □Yes □No

FOR OFFICE USE ONLY:

❑ Patient refused to sign consent form. Reason:_____

❑ Restrictions were added by the patient (see restrictions above).

❑ "Consent form" received and reviewed by:_____ on (date)_____.