Advanced Allergy & Asthma

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In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Advanced Allergy and Asthma requests that each patient sign this consent form which allows us to share protected health information with other physician offices and insurance companies.By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow us to share health information and results from tests and procedures with family members such as their spouse, parents and others. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patients consent. If you wish for your information to be released, please check **YES** below and specify which family member(s).

You have the right to revoke this consent in writing except where we have already made disclosures in alliance to your prior consent. **YES**_____ **NO**_____

Name of

individuals(s)_____

_____

Authorization to Leave Voicemail

YES_____ **NO**_____

Medication Authorization

I give Advanced Allergy and Asthma permission to obtain an active medication list through electronic prescribing of all medications taken by the patient.

YES_____ **NO**_____

Patient Name:_____

Patient/Guardian Signature_____ Date_____