ADVANCED ALLERGY & ASTHMA SPECIALISTS

NOTICE OF PRIVACY PRACTICES

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my Individually Identifiable Health Information ("Protected Health Information") and Medical Record Information by Advanced Allergy & Asthma Specialists, Inc. (herein, the "Practice") in order to carry out treatment, payment or health care operations.

I acknowledge and agree the Practice may disclose my Protected Health Information and Medical Record Information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: ______________________
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I agree the Practice may also disclose the following types of information contained in my medical record:
(please initial the appropriate categories listed below)

________ HIV/AIDS Information
________ Mental Health Information
________ Substance Abuse Information
________ Sexually Transmitted Disease Information
________ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s):
(please initial the appropriate spaces below) :

________ Via e-mail to the Patient's designated e-mail address which is: ____________________________. I acknowledge responsibility for notifying the Practice of any changes to this e-mail address.

________ Via regular mail with any envelopes being marked Personal and Confidential and addressed to me, the patient.

________ Via telephone, if I contact the Practice and provide the appropriate information which will include My Name, Social Security Number and Unique Personal Identifier.

________ Via fax to my designated fax number which is: _________________.

You, the Patient or an Authorized Representative, should review AAAS's Notice of Privacy Practices for a more complete description of the potential release and use of such information; you have the right to review such Notice prior to signing this Consent Form.

AAAS reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You, the Patient or an Authorized Representative, retain the right to request we further restrict how your Protected Health Information is released or used to carry out treatment, payment, or health care operations. AAAS is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

At all times you, the Patient or an Authorized Representative, retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat you, the Patient, should you or an Authorized Representative, not sign this Consent Form. If you, the Patient or Authorized Representative, sign this Consent and then choose to revoke it, the Practice has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent the Practice is required by law to treat individuals).

I have read and understand the information in this consent and have received a copy of this consent. I am the Patient, or the Authorized Representative to act on behalf of the Patient, eligible to sign this document verifying consent to the above terms.

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Signature of Patient or Authorized Representative

____ Date: ______________________ Time: __________ AM/PM
Please print Name of Signatory above

- Please explain Authorized Representative's relationship to Patient and include a description of Authorized Representative's authority to act on behalf of the Patient:

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