ALLERGY CONSULTANTS, P.A.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Allergy Consultants, PA to use and disclose protected health information (PHI) about me to carry out **treatment, payment and health care operations** (TPO). The Notice of Privacy Practices provided by Allergy Consultants, PA describes such uses and disclosures more completely). A copy of the Notice of Privacy Practices is available on our website, electronically by request and in all of our offices in an easy to read booklet form. By signing this form I attest that **I have received, read and understand the Notice of Privacy Practices**.

Allergy Consultants, PA reserves the right to revise its Notice of Privacy Practices at any time. I have the right to request that Allergy Consultants, PA restrict how it uses or discloses my PHI to carry out TPO.

With this consent, Allergy Consultants, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, amongst others. _____yes _____no

With this consent, Allergy Consultants, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
_____yes _____no

With this consent, Allergy Consultants, PA may email to me any information or notices that assist the practice in carrying out TPO. _____yes _____no

The following person (s) may contact Allergy Consultants, PA inquiring in regards to my health information. You have my permission to release my health information to them.

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Allergy Consultants, PA may decline to provide treatment to me.

Signature of Patient or Legal Guardian:_____

Print Patients name:_____Date:_____

Print name of Legal Guardian, if applicable:_____