



Patient Consent

The patient indicated below is presented for evaluation and treatment at The Asthma & Allergy Institute.

Consent to Release Information and Payments of Benefits

I hereby authorize the use and disclosure of any medical or insurance information by mail, telephone, cell phone, fax, or e-mail, concerning my illness and treatment, payment and healthcare operations for services rendered at The Asthma & Allergy Institute. I further authorize that payment be made directly to The Asthma & Allergy Institute for services provided to the patient indicated herein. I further authorize the release and disclosure of medical information concerning my illness and/or treatment to my referring/consulting/requested physician, as deemed appropriate by The Asthma & Allergy Institute.

Acknowledgement of Financial Responsibility

I am aware that I will be responsible for any charges for services I receive at The Asthma & Allergy Institute, including any applicable co-payment and deductibles that we are contracted to collect. In the event this account is turned over for collection, I agree to pay all costs of collection, including reasonable attorney fees.

Receipt of Notice of Privacy Practices

I certify that I have received a copy of the *Notice of Privacy Practices* for this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of charges, or in the performance of The Asthma & Allergy Institute's healthcare operations. The Notice of Privacy Practices also describes my rights and The Asthma & Allergy Institute's duties with respect to my protected health information. The Notice of Privacy Practices is posted in our office, our waiting room and available at the front desk. Our Notice of Privacy Practices is subject to change. We will notify you of any changes should they occur.

I have read and understand the above:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Please list (2) persons that have permission to access your records in case of an emergency or necessity.

1. \_\_\_\_\_ Phone: \_\_\_\_\_ Relation \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_