Allergy & Asthma Care

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Board Certified, Allergy and Immunology

Specializing in Adult and Pediatric Allergies and Asthma

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that Personal Healthcare Information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers in obtaining patient consent for the uses and disclosures of health care information when carrying out treatment, payment, or other health care operations.

As our patient, you should know that we respect the privacy of your personal medical records and will do all we can to secure that privacy. We strive to take every reasonable precaution to protect it at all times. When appropriate or necessary, we disclose the minimum of information required for the purposes of treatment, payment or other health care operations, and only to those we believe are in need of that information so they can provide the service and care that is in your best interest.

We may also have indirect treatment relationships with you (for example, through laboratories that only interact with physicians and not with patients), and may have to disclose Personal Healthcare Information for the purposes of treatment, payment or other health care operations in those situations. These entities are usually not required to obtain patient consent.

We fully support your access to your personal medical records, which can be provided to you after receipt of a written and signed release request. You also have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), a copy of which can be provided to you by our staff.

You may refuse to consent to the use and disclosure of all or part of your Personal Healthcare Information, but this must be done in writing. If you choose to give unrestricted consent today by signing this document, at any future time you may still revoke consent to, or request restrictions on, the use and disclosure of all or part of your Personal Health Information by notifying us in writing of the change. You cannot, however, revoke actions that have already been taken which relied on this or a previously signed consent. Please also note that, under this law, we have the right to refuse to treat you should you refuse disclosure of your Personal Health Information.

Please sign and date below if you consent to the use and disclosure of your Personal Healthcare Information as outlined above. Thank you.

Date __ __ /__ __ /__ __ __ __ **Signature** _____

(For patients under 18 years of age, parent/guardian must sign.)