FAMILY
Allergy & Asthma
Breathe Right... Live Well.

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CONSENT AND ACKNOWLEDGEMENT FORM

Signatures required by HIPAA

I hereby consent to Family Allergy & Asthma (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competency of health care professionals.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

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Signature of Patient or Parent or Legal Guardian

______________________________ ____________________
Print name of Patient Patient Date of Birth

______________________________ ____________________
Print name of Parent or Legal Guardian (optional) Date

ADDITIONAL CONSENT:

I, ______________________________, authorize the following person(s) to obtain (written/verbal) health information on (myself/child) until revoked in writing by myself.

Signature:______________________________ Date: ____________________

Name: ____________________ Relationship: ____________________ Ph # ____________________

Name: ____________________ Relationship: ____________________ Ph # ____________________

SCHOOL AUTHORIZATION:

I authorize the limited disclosure of health information regarding medication and emergency treatment to my child's school for ______________________________, and said authorization will remain in effect unless revoked by me in writing.
(child's name)

Signature ______________________________ Date ____________________
Parent or Legal Guardian

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