Individual Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, Associated Allergists & Asthma Specialists (also named as AAAS) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that [name of covered entity] and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have received a ***Notice of Information Practices*** that fully explains the uses and disclosures that AAAS will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. AAAS has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that AAAS cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that AAAS reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that, if I do not consent, AAAS may refuse to provide me health care services unless applicable state or federal law requires AAAS to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that AAAS is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or AAAS notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information:

_____

I understand that I have the right to request restriction as to the method of communications to me. I further understand that AAAS must honor this request if the *method of communication* is reasonable.

I object to uses and disclosures as follows: _____

_____

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that AAAS has already taken action in reliance on my earlier effective consent.

_____ _____

Signature of Patient or Legal Representative Signature of Witness

_____ _____

Print Name of Patient Patient Date of Birth

_____

Date