ALLERGY & ASTHMA CENTER OF MASSACHUSETTS

Allergic and Respiratory Medicine
Adult and Pediatric

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HIPAA

Patient name _____ Birthdate _____

Parent/Guardian _____
(Authorized to sign for minor child < age 18)

I have received the privacy notice of policies regarding protection of private health care information (PHI) for Allergy and Asthma Center of Massachusetts

I authorize Allergy and Asthma Center of Massachusetts to communicate with members of my immediate family and other individuals designated below for information regarding visit appointments, filling of prescriptions, matters related to filing of insurance claims and matters related to medication authorizations for minor children at school/camp. Only the minimal information necessary to facilitate my care will be divulged, except as required by law.

Other persons to whom information regarding the matters listed above include:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I wish to restrict disclosure of my PHI in the following manner (If no restrictions, list “none”):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that is part of his organization's treatment, payment, or healthcare operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, in writing, verbally, or via other electronic means.

I fully understand and accept/decline the terms of this consent.

_____	_____	_____
My Signature	Date	Received by(initials)

I revoke the terms of this consent.

_____	_____	_____
My Signature	Date	