EASTERN ALLERGY & ASTHMA SPECIALISTS

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Acknowledgement of Notice and Consent to Use and Disclose Health Information

This Acknowledgement of Notice and Consent authorizes Eastern Allergy & Asthma Specialists, LLC (EAAS) to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices: EAAS has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. The Privacy Notice is available as part of your new patient packet and can also be found at our front desk and on our website (eaasde.com).

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change.

Permission to Release Information to Additional Parties
Confidentiality laws state that no medical information (e.g. diagnosis, treatments) may be released to any other person(s) without the written consent of the patient (or guardian if applicable). By filling out the following, I authorize EAAS to also provide protected health information to the following individuals:

Name _____ Relationship _____ Phone: _____

Name _____ Relationship _____ Phone: _____

Consent to Treat a Minor:
By law, minors (< 18 years of age) must be accompanied by a parent or legal guardian. If a parent or guardian is unable to accompany the minor, you must have a signed release on file. Please list below the name(s) of person(s) you wish to give permission to accompany your minor and to consent to any necessary examination and treatment to be rendered by the physician.

Name _____ Relationship _____ Phone: _____

Name _____ Relationship _____ Phone: _____

Acknowledgement and Consent

I have received and/or been made aware of the Notice of Privacy Practices for EAAS. I am aware that this form must be updated yearly. EAAS is authorized to use and disclose health information about (*patient name*) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient (or Patient's Personal Representative) *Date*

_____ _____
Personal Representative Name (if applicable) *Relationship*