Southwest Allergy & Asthma Center

John Van Wagoner, MD, PA

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: This office will not disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. This office complies with HIPAA and all federal and state laws regarding the privacy of your information. The Notice of Privacy Practices is available on our website under Education. A printed copy is also available upon request.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

PATIENT/GUARDIAN SIGNATURE	PATIENT NAME	PATIENT DOB

DATE COMPLETED/UPDATED

OPTIONAL: Disclosure of Protected Health Information

I understand that any and all medical care that I receive at Southwest Allergy & Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize Southwest Allergy & Asthma Center to disclose PHI regarding my treatment and medical condition to the following individuals:

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____