The Virginia Center for Allergy & Asthma

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby authorize the physicians of The Virginia Center for Allergy and Asthma to use and disclose my health information which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment, and health care operations. I understand while this consent is voluntary, if I refuse to sign this consent, the physicians of The Virginia Center for Allergy and Asthma can refuse to treat me.

I have been informed that the physicians of The Virginia Center for Allergy and Asthma have prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have been given the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent by notifying the physicians of The Virginia Center for Allergy and Asthma in writing, but if I revoke my consent, such revocation will not affect any actions the physicians of The Virginia Center for Allergy and Asthma took before receiving my revocation.

I understand that the physicians of The Virginia Center for Allergy and Asthma have reserved the righ to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request the physicians of The Virginia Center for Allergy and Asthma restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that the physicians of The Virginia Center for Allergy and Asthma do not have to agree to such restrictions, but that once such restrictions are agreed to, the physicians of The Virginia Center for Allergy and Asthma must adhere to such restrictions.

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Signature of Patient/Parent/Representative/Guardian Date

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Printed Name of Above Signature

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Relationship to Patient