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## **Consent to Use and Disclosure of Protected Health Information**

### **Use and Disclosure of Your Protect Health Information**

Your protected health information will be used by Regional Allergy& Asthma Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

### **Notice of Privacy Practices**

Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### **Requesting a Restriction on the Use of Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information.

Regional Allergy& Asthma Center may or may not agree to restrict the use or disclosure of your protected health information.

If Regional Allergy & Asthma Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Rights to Change Privacy Practices**

Regional Allergy & Asthma Center reserves the right to modify the privacy practices outlined in the notice.

### **Signature**

**I have reviewed this consent form and given my permission to Regional Allergy & Asthma Center to use and disclosure my health information in accordance with it.**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Relationship of Patient Representative to Patient

\_\_\_\_\_  
Date