

Consent to Use and Disclose Health Information

By signing this form, you are granting consent to Denver Allergy and Asthma Associates to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: accessing our web site at www.DenverAllergy.com or by contacting our main office at 303-234-1067 and requesting a copy be sent to you. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

The physicians at Denver Allergy and Asthma Associates, P.C., participate with Western States Clinical Research in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will not release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Print Patient Name _____

Patient/Responsible Party Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Denver Allergy and Asthma Associates the use or disclosure of my Personal Health Information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Specific description of PHI to be released: All test results and medical records pertaining to any testing and treatment performed by Denver Allergy and Asthma Associates, P.C.

0 Yes 0 No I am requesting my PHI (medical records) for my own use.

0 Yes 0 No I am requesting that my PHI (medical records) be sent to my health care provider:

Primary Care Physician Name (First and Last): _____

Other Medical Providers (First and Last): _____

I understand that this authorization will expire 12 months of signature date.

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

Print Patient Name _____ Initials: _____

Patient/Responsible Party Signature _____ Date _____