

Consent for Release of Personal Health Information

Patient's legal name _____ Acct# _____

I, _____ authorize Denver Allergy and Asthma Associates, P.C. to also use or disclose my health information as indicated by my responses below.

1. My medical condition and information may be discussed with the following persons.

DO NOT list a physician on this form.

Name _____ Relationship _____

Name _____ Relationship _____

Please circle your response.

2. Leave a message on my phone voice mail or answering machine? YES NO

3. Leave a message with a person who answers my home phone? YES NO

4. Contact me at work and tell them who is calling if asked? YES NO

5. Leave a message on my work phone voice mail or answering machine? YES NO

6. May contact me by email at _____

Signature of patient (or patient's representative) _____ Date _____

Printed legal name of patient (or patient's representative) _____