ALLERGY ASTHMA
AND SINUS CENTERS

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(815) 729-9900

Consent for Release, Use of Confidential Information, and Receipt of Notice of Privacy Practices

I Name of Patient or Authorized Agent, hereby give my consent to Allergy Asthma and Sinus Centers to use or disclose, for purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of Name of Patient.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by our website and/or reception area.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I consent to be contacted by Allergy Asthma and Sinus Centers or anyone calling on its behalf, for any and all purposes, at any telephone number, physical or electronic address you provide, or which you may be reached, including any wireless telephone number. I agree that Allergy Asthma and Sinus Centers may contact you in anyway, including calls or pre-recorded or artificial voice or text messages delivered by an automatic telephone dialling system, or email messages delivered by an automatic emailing system.

I expressly acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. I agree to promptly notify us at any time your contact information changes.

X SIGNATURE OF PATIENT (PARENT IF A MINOR)

DATE: MM - DD - YYYY

If you are not the patient, please specify your relationship with the patient.

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