

ALLERGY AND ASTHMA ASSOCIATES OF PITTSBURGH
Adult and Pediatric Allergy, Asthma, and Clinical Immunology

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Diplomats:
American Board of Internal Medicine
American Board of Allergy and Clinical Immunology

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Allergy and Asthma Associates requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company. This also gives us permission to retrieve health information from UPMC health facilities such as diagnostic test results. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow us to share health information and results from tests and procedures with family members such as their spouse, parents, and others. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patients consent. If you wish your information released please check **Yes** below and specify which family member (s).

You have the right to revoke this consent in writing except where we have already made disclosures in alliance on your prior consent. **YES** _____ **NO** _____

Name (s) of individual (s) _____

Authorization to Leave Message on Answering Machine

YES _____ **NO** _____

Medication Authorization

This is to give Allergy and Asthma Associates permission to obtain an active medication list though electronic prescribing of all medications taken by the patient. **YES** _____ **NO** _____

Patient Name: _____

Patient Signature: _____ **Date:** _____