***Allergy and Asthma Center***

***Anita N. Wasan, MD, FAAAAI FACAAI***

**PRIVACY AND CONFIDENTIALITY RELEASE OF INFORMATION**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice describes your rights under the law. You ascertain that by your signature that you

have reviewed our notice before signing this consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health

Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in our electronic medical record system, Practice Fusion. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

1. I give permission for Dr. Anita Wasan or staff to discuss my treatment with my spouse/partner/family members about my presence in the office. Such discussion may include my diagnosis and treatment.

**YES\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_**

Names of person (s) I designate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I give permission for Dr. Anita Wasan or staff to discuss my appointments, my treatment, or test results I have had with the above person (s) I have designated when I may/may not be present.

**YES\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_**

1. I give permission for Dr. Anita Wasan or staff (and the Electronic Medical Record) to leave messages/emails/texts for me regarding appointments and/or test results. I give permission to leave voice mails on the answering machine/voice mail on the telephone number below which I designate.

**YES\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_**

Telephone number to leave message is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I can revoke this authorization at any time in writing.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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