SIRVEN & ASSOCIATES
ALLERGY & ASTHMA
CENTER

SIRVEN & ASSOCIATES ALLERGY AND ASTHMA CENTER

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent the use or disclosure of my health information by Viviana Sirven, M.D. For the of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Viviana Sirven, M.D. I understand that diagnosis or treatment of me by Viviana Sirven, M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, **Viviana Sirven, M.D**, is not required to agree to the restrictions that I request. However, if **Viviana Sirven, M.D**, agrees to the restriction that I have requested, the restriction is binding on **Viviana Sirven, M.D**.

I have the right to revoke this consent, in writing al any time, except to the extent that **Viviana Sirven, M.D**, has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house, This protected health information relates to my past, present or future physical or mental health or condition and identifies me, there is a reasonable basis to believe the information may identify me.

I understand I have the right to reiew **Viviana Sirven, M.D**, Notice of Privacy Practices prior to signing this document. The **Viviana Sirven, M.D**, Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Notice of Privacy Practices also describes my rights and the **Viviana Sirven, M.D**, duties with respect to my protected information.

Viviana Sirven, M.D, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of patient or personal Representative

Name of patient or personal Representative

Date

Description of personal Representative's Authority

One Seventeen Professional Arts Center
8200 SW 117th Avenue - Suite 402 - Miami, FL 33183

Phone (305) 442-4116
Fax (305) 442-7282

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This Consent is to certify that I understand that the Sirven and Associates Allergy & Asthma Center is not responsible for obtaining benefits from my insurance in regards to any blood work drawn here at the office/and or any requisition given for blood work to be drawn at the lab. I am aware that any bills received from Quest and/or LabCorp is solely my responsibility. I consent that as a patient, it is my responsibility to call my insurance prior to having any services rendered to obtain my benefits.

Thank you for your understanding,

Sirven and Associates Allergy & Asthma Center

Preferred Lab **(Please specify)**: Quest: _____ LabCorp: _____

_____
Patient Full Name

_____
Patient/ Guardian Signature

_____
Date

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SIRVENMDS.COM