SIRVEN & ASSOCIATES ALLERGY & ASTHMA CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Authorization

Name _____ Address _____

Phone _____ City/State/Zip Code _____

Date of Birth _____ email _____

SECTION B: To The Patient (Please read the following statements carefully):

Purpose of Consent: By signing this form (Consent), you will consent to the use and disclosure by Sirven & Associates Allergy and Asthma Center of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read Sirven & Associates Allergy and Asthma Center's Notice Privacy Practices (Notice) before you decide whether to sign this Consent. Sirven & Associates Allergy and Asthma Center's Notice provides a description of Sirven & Associates Allergy and Asthma Center's treatment, payment activities, and healthcare operations, of the uses and disclosures Sirven & Associates Allergy and Asthma Center may make of your protected health information, and of other important matters about your protected health information. A copy of Sirven & Associates Allergy and Asthma Center's Notice accompanies this Consent. Sirven & Associates Allergy and Asthma Center encourages you to read it carefully and completely before signing this Consent.

Sirven & Associates Allergy and Asthma Center reserves the right to change its privacy practices as described in its Notice. If Sirven & Associates Allergy and Asthma Center changes its privacy practices, a revised Notice will be issued, which will contain the changes. Those changes may apply to any of your protected health information that Sirven & Associates Allergy and Asthma Center maintains.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any lime on our website, or by contacting

Sirven & Associates Allergy and Asthma Center's Office Management Staff

8200 SW 117th Ave, Suite 402, Miami, FL, 33183 | 305·442-4116

Right to Revoke. Please understand that revocation of this consent will not affect any action Sirven & Associates Allergy and Asthma Center took in reliance on the consent before feMe received your revocation. However, revocation of this consent will result in Sirven & Associates Allergy and Asthma Center being prohibited from sharing your PHI with your health insurance carrier, if applicable, and, thus, Sirven & Associates Allergy and Asthma Center's inability to bill your medical treatment to that insurance carrier. Therefore, patients that either refuse to sign this consent or revoke it after signing it will be required to self.pay for all medical treatment provided by Sirven & Associates Allergy and Asthma Center and then seek reimbursement directly from the medical insurance carrier for such treatment.

Additional Person Authorized to Access PHI: I authorize the following person(s) access to my PHI:

Name	**Relationship**	**Date**	**Date Revoked**

SIGNATURE

I, _____ , have had full opportunity to read and consider the consents of this Consent and have received a copy of Sirven & Associates Allergy and Asthma Center's Notice of Privacy Practices. I understand that, by signing this Consent, I am giving consent to Sirven & Associates Allergy and Asthma Center's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also understand I'm agreeing to allow Sirven & Associates Allergy and Asthma Center to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signature _____ Date _____ / _____ / _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it.

For Office Use ONLY: ◯ Individual refused to sign ◯ Emergency situation prevented us from obtaining acknowledgment ◯ Communication barriers prohibited obtaining the acknowledgment ◯ Other

ACKNOWLEDGMENT/CONSENT OF PATIENT RESPONSIBILITY FOR LABORATORY RELATED FEES ON BLOOD WORK DRAWN IN-OFFICE

SIRVEN & ASSOCIATES ALLERGY & ASTHMA CENTER

This consent is to certify that I understand that Sirven & Associates Allergy and 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 & Associates Allergy and Asthma Center
Office Management Staff

Patient's FULL Name: _____

Preferred Lab (Please CIRCLE one): Quest OR LabCorp

Patient / Guardian Signature

_____

Date

____ / ____ / ____

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SIRVENMDS.COM