GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Patient's Name:
Patient's Date of Birth:

1. **Consent:** I hereby voluntarily request, consent to, and authorize Asthma, Allergy & Immunology Center and its staff to provide medical care including the administration of medications as deemed necessary and advisable.
2. **Release of Information.** I hereby authorize Asthma, Allergy & Immunology Center to release to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any services rendered relating to my treatment.
3. **Physician Referral:** I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.
4. **Payment:** I understand that I am responsible for any health insurance deductibles and/or co-payments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical plan denies payment of services, I will be responsible for payment of said services.
5. **Accuracy & Integrity:** I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.
6. **No Guarantees:** I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.
7. **Contact Authorization:** I do/do not (*circle one*) authorize information to be left on my answering machine.
   Please provide us any specific instructions about the manner and location in which we may contact you below:

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I have read this form or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing and I am free to revoke my consent at any time.

Date of Visit: _____ Signature of Patient/Guardian: _____

If patient is unable to consent, please complete the following:
Patient is a minor _____ years of age
Patient is unable to sign because:

_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize the use or disclosure of the following individual's health information to the following individual(s) or organization listed below:

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____

The type and amount of information to be used or disclosed is as follows:
____Appointment reminder messages left on my answering machine
____Medication List
____List of allergies
____Immunization List
____Most recent history and physical
____Laboratory results
____X-ray and imaging reports
Note: To be filed and retained for a minimum of six (6) years

Please return forms with the insurance card(s) to the receptionist. Thank You