PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy: The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health nformation (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: SIGN HERE _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Allergy Associates of Utah

MEDICAL & FINANCIAL INFORMATION AUTHORIZATION & RELEASE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We will release information ONLY by the authorized means you have chosen. We will take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in an emergency.

I authorize the staff of Allergy Associates of Utah to release any ***financial*** information to the following people:

Name of Spouse: _____
Partner: _____
Parent or Guardian: _____
Other: _____

I authorize the staff of Allergy Associates of Utah to release any ***medical*** information to the following people:

Name of Spouse: _____
Partner: _____
Parent or Guardian: _____
Other: _____

Please check all that apply:

Telephone Communication:	**Written Communication:**
☐ Home telephone:	☐ O.K. to mail to my home address.
☐ Cell phone:	☐ O.K. to mail to my work/office address.
☐ O.K. to leave detailed message on answering machine.	☐ O.K. to fax to this number:
☐ O.K. to leave message with call back number only.	☐ O.K. to mail promotional material.
☐ Work telephone:	☐ O.K. to mail information regarding Research Studies.
☐ O.K. to leave detailed message on answering machine.	☐ Other/list any restrictions:
☐ O.K. to leave message with call back number only.	

I have received the Notice of Privacy Practices of Allergy Associates of Utah and I have been provided an opportunity to review it. I understand I may revoke any part of this authorization at any time by giving written notice to the Privacy/Security Officer at Allergy Associates of Utah.

Patient Signature: _____ SIGN HERE Date: _____

Allergy Associates of Utah

ALLERGY ASSOSCIATES OF UTAH

INSURANCE AUTHORIZATION

1.I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits or other healthcare insurance plans to Dr. Charles M. Rogers, M.D. if he accepts assignment for my insurance.

2.I authorize payment of medical benefits to Dr. Charles M. Rogers, M.D. for services described below.

SIGN HERE

_____

Signed (Insured or authorized person)

DATE: _____

PATIENTS NAME: _____