KNOW ALLERGY | KURSTEEN SALTER PRICE, MD, MS

HIPAA Patient Consent Form

I ______________________________ date of birth:______________________________
(Name)

understand that as part of my health care, Know Allergy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A means by which a third-party payer can verify that services billed were actually provided, and

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

_____***(Initial)*** **NO, I do not agree** to allow Know Allergy physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____ ***(Initial)*** YES I agree to allow Know Allergy physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following:

Please initial next to the applicable communication devices:

_____***(Initial)*** Home # ________________ Cell #________________ Work # ________________

_____ ***(Initial)* YES I agree to** allow Know Allergy physicians and healthcare staff to speak with only the following people regarding my Protected Healthcare Information.

List Name(s), relationship and phone number:

____
(print name) (relationship) (phone number)

____
(print name) (relationship) (phone number)

____
(print name) (relationship) (phone number)

______________________________ ______________________________ ____________
Patient Name (Please Print) Signature of Patient (Date)
(or Patient's Legal Representative)

Patient Refused to Sign: ______________________________ ____________
Staff Name Date

MRN#______________________________