Acct # ___________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on our website www.denverallergy.com.

Patient authorizes communication with family/friends regarding your **care and test results**.

Name ______________________________ Phone # ____________________

Name ______________________________ Phone # ____________________

Patient authorizes communication with family/friends regarding your **account and billing**.

Name ______________________________ Phone # ____________________

Patient authorizes communication with a primary care physician or other physician (first and last name):

1. ______________________________ M.D.

2 ______________________________ M.D.

Best way to contact you regarding messages, responses, test results etc.: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Please select ONE contact method for appointment reminders, office closures or other appointment related messages: ☐ Phone call to primary # listed on account ☐ Text ☐ Email ☐ Secure Email (portal registration required)

1. May we leave a message on home voicemail? ☐ Yes ☐ No ☐ N/A
2. May we leave a message with whomever answers the home phone? ☐ Yes ☐ No ☐ N/A
3. May we call your work and leave a message with the person who answers the phone? ☐ Yes ☐ No ☐ N/A
4. May we leave a message on work voicemail? ☐ Yes ☐ No ☐ N/A
5. May we contact you via Email? Email Address:______________________________ ☐ Yes ☐ No ☐ N/A
6. May we contact you via text message? #: ______________________________ ☐ Yes ☐ No ☐ N/A
   (Standard text or data usage rates may apply depending on your plan and/or carrier)
7. May we send out your PHI to a third party such as a laboratory, insurance company or any other medical provider? ☐ Yes ☐ No ☐ N/A

The physicians at Boulder Valley Asthma and Allergy Clinics, PC, participate with Western States Clinical Research in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us with the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will NOT release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies.

☐ Yes ☐ No ☐ N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

______________________________ ____________________
Signature of patient (or patient's representative) Date

____
Printed legal name of patient (or patient's representative)