

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 or it is available in our offices.

I give permission for BVAAC to contact me in the following ways. BVAAC is allowed to leave messages as indicated below. A detailed message could outline results, answer questions, give details about treatment, payments, and/or appointment reasons, etc. A short message would ask for a call back only. (You may check more than one box)

Cell Phone: _____ Detailed Message Short Message With Whomever Answers No Message

Land Line: _____ Detailed Message Short Message With Whomever Answers No Message

Work Line: _____ Detailed Message Short Message With Whomever Answers No Message

Email Address: _____

I give permission for BVAAC to communicate with the following individuals regarding my care (list as many or few as you wish):

Name: _____ Phone: _____ Relationship: _____
 Medical Information (test results, treatment, etc.) Financial Information (billing, patient balance, etc.)

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 Medical Information (test results, treatment, etc.) Financial Information (billing, patient balance, etc.)

I do not give permission for BVAAC to communicate with anyone else regarding my care: _____ (initial)

The physicians at Boulder Valley Asthma and Allergy Clinics, PC, participate 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

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.

Patient/Responsible Party Signature: _____ Date: _____

Patient Name (printed): _____ Date of Birth: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Additionally, I hereby acknowledge that I have received a copy of Boulder Valley Asthma and Allergy Clinics' Notice of Privacy Practices. This is available on our website www.denverallergy.com or may be requested in our office. I understand that I have the right to refuse to sign this acknowledgement, if I so choose.

Patient/Responsible Party Signature: _____ Date: _____

Patient Name (printed): _____ Date of Birth: _____

Office Use Only: Reason acknowledgement could not be attained on _____ (date)

Refused to Sign Emergency Situation Communication Barrier Other: _____

