# BOULDER VALLEY ASTHMA AND ALLERGY

# AUTHORIZATION FOR RELEASE OF INFORMATION

Acct#_____

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

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: _____

Land Line:_____

Work Line:_____

Email Address: _____

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

Name:_____ Phone:_____Relationship:_____
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:_____ Phone:_____Relationship:_____
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:_____ Phone:_____Relationship:_____
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:_____ Phone:_____Relationship:_____
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

# BOULDER VALLEY ASTHMA AND ALLERGY
# AUTHORIZATION FOR RESEARCH RELEASE OF INFORMATION

Acct#_____

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:_____

# BOULDER VALLEY ASTHMA AND ALLERGY
# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Acct#_____

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)