# ALLERGY AND ASTHMA INSTITUTE OF JOHNS CREEK

## CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By signing below, I hereby consent for Allergy and Asthma Institute of Johns Creek (AAIJC) to use and/or disclose information about myself (or the patient for whom I have authority to sign) that is protected under federal law, for the sole purposes of *treatment, payment, and health care operations.* I may refuse to sign this consent form. However, if I refuse to sign this consent or revoke this consent, AAIJC may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The ***Notice of Privacy Practices*** has been made available for me to review. The terms of the Notice may change from time to time, and I may request a revised copy by contacting AAIJC. I have the right to request that AAIJC restrict how my Protected Health Information is used or disclosed to carry out *treatment, payment, or health care operations*. AAIJC is not required to agree to requested restrictions; however, if AAIJC agrees to the requested restriction, it is binding.

*** BY SIGNING THIS FORM, I ALSO GIVE PERMISSION FOR AAIJC TO CONTACT ME IN THE FOLLOW WAYS ***

I agree that AAIJC may **phone** me at the phone number I have provided on the AAIJC demographic form. I will tell the receptionist which number I prefer to be used for this purpose.

I agree that AAIJC may **email** me at the address provided on the AAIJC demographic form.

I agree that AAIJC may **text message** me at the cell phone number I have provided on the AAIJC demographic form.

I understand that these methods of contact will be used to communicate information about my (or my child's) medical care. This can include treatment options, medical testing results, appointment reminders, payment options, or insurance information. When calling by phone, AAIJC has the right to leave a message with the answering machine, voicemail, or whomever answers my phone. I understand that other individuals may have access to the information left by these methods.

**It is my right to refuse the above methods of contact. However, I also acknowledge that if I refuse to allow all these methods of contact, I assume responsibility for any consequences of a delay in the treatment, payment, or health care operations.**

Information about me (or my child) is protected under federal law, and I have the right to revoke this consent, unless AAIJC has taken action in reliance on my authorization. By signing below, I recognize that the protected health information (PHI) used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Print Patient's Name: ______________________________________________

Print Name of Legal Guardian: ______________________________________________

Signature Patient or Parent/Legal Guardian: ______________________________ Date ______________