Moonhee Lee, M.D.

Diplomate American Board of Allergy and Immunology
Diplomate American Board of Internal Medicine

DATE: _____

Patient Name (First, Middle, Last) **Age** **Date of Birth** **Sex**

Name Patient Goes By **Primary Phone #** **Secondary Phone #** **Primary Health Provider**

Street Address **City** **State** **Zip** **Who referred you?**

EMERGENCY CONTACT- NAME, RELATIONSHIP AND PHONE NUMBER

List names and dates of birth of all legal guardians and persons authorized to receive patient health information. *ONLY* THE PEOPLE LISTED WILL BE GIVEN *ANY* PATIENT INFORMATION.

Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health 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 source of information for applying my diagnosis and surgical information to my bill
-means by which a third-party payer can verify that services billed were actually provided
-a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to use of my information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. 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 request the following restrictions to the use or disclosure of my health information:

*Please initial:

Accepted _____

Denied _____ _____

Signature Date