

North Georgia Allergy Asthma & Immunology, LLC

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

By signing below, I hereby consent for North Georgia Allergy Asthma & Immunology, LLC (NGAAI) 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, NGAAI 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 NGAAI. I have the right to request that NGAAI restrict how my Protected Health Information is used or disclosed to carry out treatment, payment, or health care operations. NGAAI is not required to agree to requested restrictions; however, if NGAAI agrees to the requested restriction, it is binding.

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

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

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

I agree that NGAAI may text message me at the cell phone number I have provided on the NGAAI 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, NGAAI 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 NGAAI 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: _____