Consent to Use or Disclose Medical Information

I authorize the Asthma Allergy Centre to use and disclose my health and medical information solely for the purposes of Treatment, Payment and Health Care Operations.* **I understand that for any other purpose I must sign a separate authorization form.**

***Treatment- Includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other health care Providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.**

***Payment- Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization.**

***Health Care Operations- Includes the necessary administrative and business functions of our office.**

You have been given a copy of our "Notice of Privacy Practices". This contains additional information about your rights and our responsibilities concerning your medical information.

We reserve the right to modify our Privacy Notice in accordance with the law. You have a right to receive the most recent version of our Privacy Notice upon request**.**

I understand that I have the right to revoke this CONSENT provided I do so in writing, except to the extent that the Asthma Allergy Centre has already used or disclosed the information in reliance on this CONSENT.

_____ _____

Date Signature of Patient OR
Signature of Person Authorized by Law

_____ _____

Date Acknowledge Patient Privacy Notice Received