

Dilley Allergy & Asthma Specialists
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Patient Consent For The Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions. I understand that this consent applies to me as the patient, or to the patient(s) indicated below for whom I am the parent, guardian, or legal representative.

I understand that by signing this form I consent to the following:

Sharing Information for purposes of treatment: You will share information with all members of a treatment team, both within this office and with other providers [personal and institutional] in order to provide quality care and the educational/wellness programs specified in my insurance plan;

Sharing of Information for Purposes of Payment: You will share all necessary information with insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.,] and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to] claims representatives, data warehouses, billing companies]

Sharing Of Information For Purposes Of Operations: You will share all information necessary for ongoing operations of this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

Sharing Of Information With Assignment To Others: You will share information with the following individuals whom I have designated to function on my behalf as needed:

First and Last Name	Relationship	Phone Number
	<input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____	

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____ Date

Patient's Name [printed] (Complete if you are the patient)

_____ Date

Patient, Guardian, or Legal Representative's Signature