711 Old Ballas Road, Suite 100
Creve Coeur, MO 63141

Patient Consent for Use and Disclosure of Protected Health Information for Allergy & Asthma Consultants.

With my consent, Allergy & Asthma Consultants, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Allergy & Asthma Consultants reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices my be obtained by forwarding a written request to Allergy & Asthma Consultants at 711 Old Ballas Road, Suite 100, Creve Coeur, MO 63141.

With my consent Allergy & Asthma Consultants may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists the practice carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent Allergy & Asthma Consultants, may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Allergy & Asthma Consultants may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, or patient paperwork with appointment information.

We may disclose information to Midwest Clinical Research for a source of data for medical research. Signing this document, you give permission to Dr. Robert Onder at Midwest Clinical Research to use your health information that identifies you for as a candidate for the research study.

I have the right to request that Allergy & Asthma Consultants restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Allergy & Asthma Consultants use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Allergy & Asthma Consultants may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Patient's Name

_____
Print Name of Patient or Legal Guardian

_____
Date

IF OVER THE AGE OF 18:

Please list any person in the space provided below that you would like to allow us to speak with in regards to your medical care, insurance items, billing and laboratory results among others:

_____
Name

_____
Relationship

_____
Date

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I, _____, hereby give permission to Allergy & Asthma Consultants, PC to access all my medications prescribed to me by other physicians as needed for my medical care.

_____
SIGN

_____
PRINT

_____
DATE