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Patient Consent To Disclose Health Information (optional)

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

Sharing Information for Purposes of Treatment: Apex Allergy and Asthma, PLLC (AAA) 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 with quality care and the educational/wellness programs specified in my insurance plan.

Sharing of Information for Purposes of Payment: AAA 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 representatives involved in the billing process [including, but not limited to claims representatives, data warehouses, billing companies].

Sharing of Information for Purposes of Operations: AAA 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
	[ ] Spouse [ ] Grandparent [ ] Sibling [ ] Other:_____	
	[ ] Spouse [ ] Grandparent [ ] Sibling [ ] Other:_____	
	[ ] Spouse [ ] Grandparent [ ] Sibling [ ] Other:_____	
	[ ] Spouse [ ] Grandparent [ ] Sibling [ ] 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 already based on this prior consent will be permissible.

Patient's Name [printed]: _____

_____

Patient, Guardian, or Legal Representative's Signature Date