**GLEN ALLERGY AND ASTHMA**

**2550 Compass Road, Unit K**

**Glenview, IL 60026**

**Agreements and Authorizations**

**Privacy Notice and Acknowledgement**

I acknowledge that I have received Glen Allergy and Asthma Notice of Privacy Practices.

**Assignment of Insurance Benefits**

I hereby authorize payment to be made directly to Glen Allergy and Asthma for insurance benefits payable to me.

**Financial Policy**

I understand that I am financially responsible to Glen Allergy and Asthma for all services rendered to me whether covered or non-covered, as defined by my insurance company, which are not paid by any of my insurance carriers.

**Authorization for Disclosure of Medical Information**

This authorization provides that my physician/provider of service may release clinical information related to my diagnosis and treatment, which may be requested by my insurance company or a designated agent. This information also includes all records requested by any insurance company for the purpose of enabling that insurance company to evaluate my claims or its liability under such policies or contracts or coordinating benefits pursuant to such policy or contract provisions.

**Vaccinations**

I authorize my vaccination administration history to be released to the Illinois Department of Public Health.

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Name of patient (print) Date of birth

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Signature of patient Date

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Printed name and signature of patient representative Date

(required if patient is a minor or an adult unable to sign this form)

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Relationship to patient