PEACHTREE ALLERGY AND ASTHMA CLINIC, P.C.

1800 Peachtree St. NW, Suite 720
Atlanta, Georgia 30309

820 Ebenezer Church Rd., Suite 101
Sharpsburg, Georgia 30277

2740 Bert Adams Rd. NW, Suite 150
Atlanta, Georgia 30339

PATEINT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION (PHI)

I consent to use or disclosure of my protected healthcare information (PHI) by Peachtree Allergy and Asthma Clinic, P.C., to carry out treatment, payment and healthcare operations (TPO). By my signature on this document, I understand that diagnosis or treatment, obtaining payment for my healthcare bills from third party payors, and conduction healthcare operations is conditioned on my consent.

My "protected healthcare information" means individually identifiable health information held or disclosed by the practice. This information may be communicated electronically, verbally, or written and may be created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health or condition and identifies me.

With this consent, Peachtree Allergy and Asthma Clinic, P.C. may call my home or other alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance, billing, or collection matters, and any calls pertaining to my clinical care, including laboratory results, prescription calls (or faxes) to pharmacists, etc.

With this consent, Peachtree Allergy and Asthma Clinic, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, billing and insurance items, etc.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Peachtree Allergy and Asthma Clinic, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer at:

Privacy Officer
Peachtree Allergy and Asthma Clinic, P.C.
1800 Peachtree St. NW, Suite 720
Atlanta, Georgia 30309

I have the right to request that Peachtree Allergy and Asthma Clinic, P.C. 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 my signature on this form, I consent that Peachtree Allergy and Asthma Clinic, P.C. may use and disclose my protected healthcare information (PHI) to carry out treatment, payment, and operations (TPO).

I may revoke my consent in writing except to the extent the practice has already made disclosures in good faith upon my prior consent. If I do not sign this consent, or later revoke it, Peachtree Allergy and Asthma Clinic, P.C. may decline to provide treatment to me.

Print Patient Name	Signature of Patient or Legal Guardian	Date
Print Name of Person Signing Form	Relationship to Patient	

NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given the opportunity to review Peachtree Allergy and Asthma Clinic's Notice of Privacy Practices containing a complete description of my rights to privacy and the uses and disclosures of health information. I understand that Peachtree Allergy and Asthma Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice's Privacy Officer at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: ____

Signature of Patient or Authorized Person: ______________________________

Relationship to Patient: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: ______________________ Initials: ______________________

Reason: ____

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