



**New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations**

I understand, with this signed consent, Arizona Allergy Associates may use and disclose my/my child's health information to carry out treatment, payment, and healthcare operations. I understand that as part of my healthcare, Arizona Allergy Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. Please refer to our Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy to read.

Arizona Allergy Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by sending a written request to Arizona Allergy Associates Privacy Officer at 8140 East Cactus Rd., Suite 710, Scottsdale, AZ 85260.

I have the right to request that Arizona Allergy Associates restrict how it uses or discloses my/my child's healthcare information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to the restrictions requested. 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, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, Arizona Allergy Associates will be unable to provide treatment for me/my child.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of Arizona Allergy Associates treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient's Name

Date

Patient/Parent/Guardian Signature

Print Name of Patient/Parent/Legal Guardian

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused, as permitted.
- Consent added to the patient's medical record on _____.