ALLERGY&ASTHMA CENTER
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PATIENT CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the Allergy and Asthma Center of Northern New Jersey (AACNNJ) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). AACNNJ's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have received a copy of the Notice Of Privacy Practices prior to signing this consent. AACNNJ reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, AACNNJ may call my home or other alternative 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 items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent AACNNJ may mail to my home or other alternative location any items that assist with the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I may request in writing that you restrict how my private health information (PHI) is used for disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. If I do not sign this consent, or later revoke it, AACNNJ may decline to provide treatment to me.

PATIENT NAME OR LEGAL GUARDIAN (IF UNDER 18) — *please print*

RELATIONSHIP TO PATIENT

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE