DALLAS ALLERGY & ASTHMA CENTER

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PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that as part of my healthcare, Dallas Allergy & Asthma Center (DAAC) originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations.

Dallas Allergy & Asthma Center *Notice of Privacy Practices* provides specific information and complete description of how my personal health information (PHI) may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices*,and understand that I have the right to review the notice prior to signing this authorization. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Dallas Allergy & Asthma Center is not required to agree to the restrictions requested. I may revoke this authorization at any time in writing except to the extent that Dallas Allergy & Asthma Center has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list family members or other persons, if any, whom may inquire and/or be informed about your general medical concerns/condition/diagnosis:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Other restrictions on the use/or disclosure of my personal health information:

_____

_____

_____	_____	_____
Signature of Patient/Guardian	Date	Witness
_____	_____	_____
Print Patient Name/Guardian	Date	Print Name of Witness

DAAC may use my personal health information to screen for research studies (Drs. Gross, Ruff and Wierzbicki).

_____	_____
Signature of Patient/Guardian	Date