Charlottesville Allergy and Respiratory Enterprises, PLLC
1532 Insurance Lane, Charlottesville, Virginia 22911

Arvind Madaan, MD, FAAAAI, FACAAI
Diplomate, American Board of Allergy and Immunology

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities & health care operations.

Notice of Privacy Practices: Please find enclosed a copy of our Notice of Privacy Practices. You may keep the Notice for your records. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practice, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke Consent: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that the revocation of this consent will not affect any action we took before your revocation, and that we may decline to treat you or continue treating you, if you revoke this consent.

I have had full opportunity to read and consider the form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient's Name: _____ Date of Birth: _____

May we address you by your name in the waiting room? ☐Yes ☐No

Would you like to keep a copy of the Notice of Privacy Practices? ☐Yes ☐No

Patient's Signature: _____ Date of Birth: _____

OR

Personal Representative Name: _____ Relationship: _____

You are entitled to a copy of this consent after you sign it. Thank you.