

# DallasAllergyImmunology

THE CONSENTS BELOW ARE REQUIRED BY FEDERAL REGULATIONS

\_\_\_\_\_  
Patient Name

With my consent, the physicians may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to this practice's Notice of Privacy Practices for a more complete description of such uses and disclosures.(This permits us to treat you and share information with your other physicians and insurance.)

\_\_\_\_\_ (Please initial)  
Yes                      No

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physicians reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy practices may be obtained by forwarding a written request to DallasAllergyImmunology, Privacy Officer at 7777 Forest Lane, Suite B332, Dallas, TX 75230.(This says that you know you can ask to see the details.)

\_\_\_\_\_ (Please initial)  
Yes                      No

With my consent, the physician's office may call my home or other designated 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 may call pertaining to my clinical care, including laboratory results among others.(This permits us to call you and leave a message.)

\_\_\_\_\_ (Please initial)  
Yes                      No

With my consent, this practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. (This permits us to send you letters)

\_\_\_\_\_ (Please initial)  
Yes            No

With my consent, this practice may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that this practice 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.(This permits us to send emails to you.)

\_\_\_\_\_ (Please initial)  
Yes            No

With my consent, this practice may fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. (This permits us to send you a fax.)

\_\_\_\_\_ (Please initial)  
Yes            No

From time to time opportunities become available for patients to participate in clinical research studies. These studies are optional, but may be attractive to you. Are you interested in hearing about studies for which you may qualify? (This permits us to let you know about research opportunities.)

\_\_\_\_\_ (Please initial)  
Yes            No

May we leave information with a spouse or significant other?

\_\_\_\_\_ (Please initial)  
Yes            No

For any patient above the age of 18, still living at home or at college, may we discuss your appointments/treatment/insurance matters with your parent(s) or guardian?

\_\_\_\_\_ (Please initial)  
Yes            No

By signing this form, I am consenting to the practice's use and disclosure of my Protected Health Information to carry out Treatment Payment and Health Care Operation.

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, this practice may decline to provide treatment to me. I have read and understand the guidelines of this practice.

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Signature of Patient or Responsible Party

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Date

## NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists may be reported for investigation at the following address:

Se pueden presentar quejas acerca de médicos así también como otras personas autorizadas y registradas por la Junta de Examinadores Médicos de Texas (Texas State Board of Medical Examiners). Incluyendo a ayudantes médicos y acupuntristas, para su investigación, en la siguiente dirección:

Texas State Board of Medical Examiners  
Attention Investigations  
1812 Centre Creek Drive, Suite 300  
P. O. Box 149134  
Austin, TX 78714-9134

