ARIZONA ALLERGY ASSOCIATES

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand, with this signed consent, AAA may use and disclose my/my child's health information to carry out treatment, payment and healthcare operations. I understand as part of healthcare, AAA originates and maintains paper and/or electronic records describing my or my child's health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. 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. AAA reserves the right to revise its Notice at any time and a copy can be obtained by any patient/parent by sending a request to our offices.

I have the right to request that AAA restrict how it uses or discloses my/my child's healthcare information. 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, AAA will be unable to provide treatment for me/ my child(ren).

Signature	Name of Patient	Relationship to Patient
Printed Name	Date of Birth of Patient	Date form signed
AAA Witness Signature	Date	Witness Printed