

Asthma & Allergy Associates, PC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential, and absolutely not available to anyone without your expressed written consent. Our medical record of your care remains the physical property of Asthma & Allergy Associates, PC. The State of Colorado has supported this law. Forms are available to you which will allow you to authorize in writing the release of a copy of specific parts of your medical records to another physician or medical practice. A small fee is charged for making copies and mailing them. Patients who are of age less than 18 years, remain under the legal authority of their parents/legal guardians until emancipated.

Health Care Operations

There remains certain instances where, in the process of delivering good medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical & administrative professionals within this practice, without expressed written permission of each and every specific incident by you. Some examples include:

- a. Calling your pharmacy for a renewal of your medication
- b. FAXing your pharmacy with a prescription
- c. Calling your insurance carrier for billing/reimbursement
- d. FAXing your insurance carrier with documentation of care
- e. Calling your Primary Care Physician with results of care
- f. Writing or FAXing your PCP with questions or results of care
- g. Transcription of letters, consults, test results, progress notes, appointment reminders, etc. within the practice
- h. Handling of the mail; newsletters, claims, bills, referrals, etc.
- i. Requesting that the office/reception staff call you to schedule an appointment, acquire a referral, discuss medications or behavior preparations prior to or after a medical visit
- j. Verbal or written correspondence with Insurance Companies; yours and ours
- k. Discussing (verbal & written) complex evaluation and management of your health with peers and/or experts in medical care
- l. Discussing an opportunity to enroll you in ongoing Asthma & Allergy Research; and/or continuation in Research studies
- m. Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care, and with the administrative staff to coordinate referrals, send appointment reminders, file & store medical records, order/receive antigen, submit claims and manage accounts billing, co-pays
- n. Etc.

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law; Federal, State, or by Court Order. ***(Please refer to consent below)***

Your Rights under the Law

1. You have the right to expect that we will respect and honor your personal medical information privacy
2. You have the right to request a copy of your medical record for yourself and/or sent to another physician
3. You have the right to discuss any and all information contained in your medical record with your provider of care in a private environment
4. You have the right to complain to the Practice Administrator on how your medical information is guarded, handled, and released (or not released) under the tenants of the law
5. You have the right to express concerns about the law and it's limitations to the US Government Department of Health and Human Services

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "Needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

It is my responsibility to enforce this policy within this practice.

David L. Root
Practice Administrator

(today's date)

(full name of patient)

_____, I, _____ consent to allow Asthma & Allergy Associates to use or disclose personal health information about me for the purpose of treatment, payment, and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as also described above.

Patient Signature

(Signature of parent/guardian)

If patient is a minor child

I understand that if I wish to further restrict disclosure of my private medical information, then health care operations may be delayed, hindered, or denied and I take full responsibility for that decision. I request:

