Allergy and Dermatology Specialists | ***Allergy, Asthma & Immunology Division***

LONGEVITY PHYSICIAN SPECIALISTS

Eric J. Schmitt, MD • Michael Calvin, PA-C

Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

You may review our Notice of privacy practices prior to signing this consent. A copy for your review is kept in patient waiting area or you may request a personal copy at the Front Desk.

Use and Disclosure of your Protected Health Information (PHI)

Your Protected Health Information will be used by Longevity Physician Specialists or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

My preferred contact phone number is: _____-_____-_____ which is my ❑Home ❑ Cell

Appointment Reminders will be sent via phone, SMS (text message) or through our secure Patient Portal.

If unable to reach me: ❑ You may leave a detailed message that may include my Personal Health Information.
❑ Please leave a message asking me to return your call.

Release of Information:

❑Yes, I authorize the release of information including the diagnosis, examination rendered to me, and claims information.

List the name of the individual(s) this information may be released to _____

❑ No, my Personal Health Information is only to be released for treatment purposes.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____	_____	____/_____/_____
Name of Patient (print)	**Signature of Patient**	**Date**
_____	_____	____/_____/_____
Name of Patient Representative / Relationship	**Signature of Patient Representative**	**Date**

Office Representative _____Date _____/_____/_____

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