Allergy Immunology Clinic of East Bay
2320 Woolsey St/ off Telegraph Ave, Berkeley, CA 94705
(925) 270- 5119

Name: _____Date_____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is Allergy and Immunology Clinic of East Bay's policy to require your reading and signing this consent form prior to the treatment or any other medical services.

I hereby authorize Allergy and Immunology of East Bay to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered and / or engaging in health care operations.

I understand that Allergy and Immunology Clinic of East Bay's Notice of Privacy describes in more detail the types of uses and disclosures of Health Information. I understand that I have the right to review such Notice prior to signing.

I understand that I have the right to request a restriction on the use or disclosure of my Health Information. I further understand that Allergy and Immunology Clinic of East Bay is not obligated to agree to my request. I have the right to revoke this consent, by submitting it in writing to Allergy and Immunology Clinic of East Bay.

I understand that if I choose not to sign this consent, Allergy and Immunology Clinic of East Bay may withhold medical services.

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Signature: Patient, Legal Representative, Agent Date