VIRGINIA ALLERGY AND ASTHMA CENTER
Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by **Virginia Allergy & Asthma Center** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

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.

Virginia Allergy & Asthma Center may or may not agree to restrict the use or disclosure of your protected health information.

If **Virginia Allergy & Asthma Center** agrees to your request, the restriction will be binding on the practice. 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 Practices
Virginia Allergy & Asthma Center reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to **Virginia Allergy & Asthma Center** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

Signature of Patient or Patient Guardian _____ Date _____
I agree that disclosures may be made to family and friends related to my health or as needed for payment of my healthcare services. I understand that VAAC will only disclose information relevant to current treatment, I agree that VAAC may disclose health care information to: (list names of all family members or friends you wish us to speak with regarding your care.

Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number