CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS

Patient Name:
Medical Records No.:

With the increased awareness of a patient's right to confidentiality, we are asking all our patients to complete this form. This form will give the physicians and our office staff guidance as to who should be allowed to receiv information about your healthcare.

Please complete one of the options listed:

1. [ ] DO NOT DISCUSS MY MEDICAL CONDITION WITH ANYONE
   If you choose this option, STOP HERE. Sign and date at the bottom.

2. [ ] NO RESTRICTIONS – DISCUSS MY MEDICAL CONDITION WITH ANYONE
   If you choose this option, STOP HERE. Sign and date at the bottom.

3. [ ] I, _____, GIVE THE PHYSICIANS AND OFFICE STAFF OF CARLOS J. VITAL, MD, PERMISSION TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING INDIVIDUALS:

_____
Name

_____ _____
Relationship Phone

_____
Name

_____ _____
Relationship Phone

Please include on a separate piece of paper any other special instructions or limitations.

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STDs); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of Vital Allergy and Asthma Center's Notice of Privacy Practices and any changed thereto which may be associated with this authorization. I have been provided an opportunity to discuss concerns I may have about the use or misuse of my health information with Vital Allergy and Asthma Center's privacy official or other appropriate personnel.

I understand that Vital Allergy and Asthma Center assumed no responsibility for the use or misuse by other of my health information disclosed under this content. I release Vital Allergy and Asthma Center and its agents and employees from all legal liability that may arise from this consent.

THIS CONSENT IS ACTIVE UNLESS YOU FILL IN AN EXPIRATION DATE OR YOU REVOKE THIS CONSENT IN WRITING.

_____ _____
Patient Signature Date