(**Please Print**)

Patient Name:____ Date of Birth: _____/_____/_____

Marital Status: ☐M ☐S ☐W ☐D ☐Sep ☐Other

Address: (if changed)___________________________ City:__________________ State:_____ Zip:_______

Home Ph#:______________________ Cell#:_________________________ Work#:__________________

Employer Name:_____________________________Address:____________________________________

Emergency Contact:__________________________ Ph#___________________ Relationship:__________

Is the patient a full time student? ☐ Yes ☐No School attending:_________________________________

(Fill In Only If Patient Is A Minor):

Parent Name:________________________Address:_____________________________________

Ph#:_______________________________Employer:___________________________________

Parent Name:________________________Address:_____________________________________

Ph#:_______________________________Employer:___________________________________

Primary Care Doctor:__________________________________ **Address:**_________________________________

Pharmacy Name / Location:____

Patient Allergies, (Drugs and/or environmental):_______________________ _______________________

___________________________ ______________________________ _________________________

___________________________ ______________________________ _________________________

___________________________ ______________________________ _________________________

New Medical Conditions: ____

____

New Surgical History and Dates:____

____

Current Medications:

Name	For what condition	Dosage	Times per day
____________________________	________________	__________	_________
____________________________	________________	__________	_________
____________________________	________________	__________	_________
____________________________	________________	__________	_________
____________________________	________________	__________	_________

(Please list any additional information on back)

Health Information Protection Privacy Act (HIPPA)

Consent for disclosure of protected health information

By signing this form, you give consent for Allergy & Asthma Consultants PC to use and disclose your private and protected health information for the purpose of treatment and/or payment. Our Health Information Privacy information, which is located in our office waiting room, explains in detail how we use your health information. We encourage you to please pick up a copy if you are unfamiliar with this privacy act.

You can revoke any person given consent on this form by contacting our office directly by phone or written request.

Patient Name: ____ Date of Birth:________________
(please print)

I give the following listed individuals permission to speak directly to Allergy & Asthma Consultants about my medical care. I also understand I can revoke or change this list at any time.

Name:_______________________________________ relationship:___________________________

Name:_______________________________________ relationship:___________________________

Name:_______________________________________ relationship:___________________________

Signature:____ Date:______________________
(signature of parent or guardian if patient is a minor)

Relationship to patient:____

HealthlinkNY Health Information Exchange

RHIO CONSENT FORM - LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

PROVIDER: Allergy and Asthma Consultants PC

I understand that I can choose whether to allow HealthlinkNY to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I get health care. HealthlinkNY is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit the HealthlinkNY website at www.healthlinkny.com or to learn more about the statewide computer network, read the brochure, "Better Information Means Better Care" at www.ehealth4ny.org.

I understand that unless I select one of the consent choices listed below, my information may be accessed in the event of an emergency.

Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

Please carefully read the Consent Form Information Sheet about how your information is used before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form.

Please choose only one of the following two options:

☐ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT** for the Provider named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Organizations participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050

Printed Name of Patient (Last name) | (First Name) | Patient Date of Birth (MM / DD / YYYY)

Signature of Patient or Patient's Legal Representative | Relationship of Legal Representative to Patient(if applicable)

Date of signature (MM / DD / YYYY) | Print Name of Legal Representative (if applicable) Last name, first name

E-mail address of Patient