

# LISA SULLIVAN, M.D.

Specializing in Pediatric and Adult Allergy, Asthma and Immunology

## Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, \_\_\_\_\_ (name of patient or authorized agent),  
hereby give my consent to Dr. Sullivan to use or disclose, for the purpose of  
carrying out treatment, payment, or health care operations, all information  
contained in the patient record of \_\_\_\_\_.  
(Patient Name)

I acknowledge receipt of Dr. Sullivan's Privacy Practices. The notice of  
Privacy Practice provides detailed information about how the practice may  
use and disclose my confidential information.

I understand that this consent is valid until it is revoked by me. I understand  
that I may revoke this consent at any time by giving written notice of my  
desire to do so to Dr. Sullivan. I also understand that I will not be able to  
revoke this consent in cases where Dr. Sullivan has already relied on it to  
use or disclose my health information. Written revocation of consent must  
be sent to Dr. Sullivan's office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_

CC: Patients File

