LISA SULLIVAN, M.D.
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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: Patient's File

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