Victor Estrada, M.D.
Allergy, Asthma and Clinical Immunology
14615 San Pedro , # 250
San Antonio, TX 78232
Ph: (210) 490-2051
Fax: (210) 490-6758

Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions. I understand that this consent applies to me as the patient, or to the patient(s) indicated below for whom I am the parent, guardian, or legal representative.

_____ _____

_____ _____

_____ _____

I understand that by signing this form I consent to the following:

Sharing Information for Purposes of Treatment: You will share information with all members of a treatment team, both within this office and with other providers [personal and institutional] in order to provide with quality care and the educational/wellness programs specified in my insurance plan;

Sharing of Information for Purposes of Payment: You will share all necessary information with insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.,] and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to] claims representatives, data warehouses, billing companies]

Sharing of Information for Purposes of Operations: You will share all information necessary for ongoing operations of this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

Sharing of Information With Assignment to Others: You will share information with the following individuals whom I have designated to function in my behalf as needed.

First and Last Name	Relationship	Phone Number
	[ ] Spouse [ ] Grandparent [ ] Brother [ ] Sister [ ] Other_____	
	[ ] Spouse [ ] Grandparent [ ] Brother [ ] Sister [ ] Other_____	
	[ ] Spouse [ ] Grandparent [ ] Brother [ ] Sister [ ] Other_____	
	[ ] Spouse [ ] Grandparent [ ] Brother [ ] Sister [ ] Other_____	

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____ _____
Patient's Name [printed] **(Complete if you are the patient)** Date

_____ _____
Patient, Guardian, or Legal Representative's Signature Date