Consent Authorization
Timber Lane Allergy & Asthma Associates

Patient Name: _____
Date of Birth: _____

Please complete this form and return it back to us with the enclosed envelope.

By signing below, I _____
(patient or legal guardian name)

1) Consent to the use or disclosure of my protected health information by Timber Lane Allergy & Asthma Associates for the purpose of diagnosing or to conduct health care operations. I have the right to revoke this consent in writing, at any time, except to the extent that Timber Lane Allergy & Asthma Associates has taken reliance on this consent.

2) Authorize payment of medical benefits to Timber Lane Allergy & Asthma Associates.

3) Acknowledge that a copy of Timber Lane Allergy & Asthma Associate's Notice Regarding Privacy of Personal Health Information has been provided to me. (Notice is available on our website: www.tlaaa.com)

_____ _____
(Patient or legal guardian signature) (Date)

☐ I authorize TLAAA to leave personal medical information on my home/mobile answering machine.