Informed Consent

I authorize:

- Connecticut Asthma & Allergy Center LLC (CAAC) to forward any medical information to the referring physician(s) regarding (my/my child's) illness and treatment and to submit information to my employer and/or their insurance carrier (for workers' compensation only). I understand the information released may include psychiatric, drug, alcohol, and/or HIV/AIDS information. The confidentiality of this record is protected by the Federal Confidentiality Regulations 42 CFR 9 part 2 and chapter 899c of the Connecticut General Statutes. This information shall not be forwarded to anyone else without my written consent or other authorization as provided in the statutes.
- CAAC to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
- Payment to CAAC from my insurance carrier and agree to pay any applicable co-payments at the time of service. I understand that my health insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance.
- Testing and treatment procedures as deemed necessary by the CAAC physicians.

I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE LEGAL GUARDIAN FOR A MINOR), AND I ACCEPT THE TERMS AS ABOVE.

_____ _____

Patient Signature Date

If patient is a minor:

_____ _____

Signature of Responsible Party Date

_____

Relationship to patient

If you have been assigned guardianship of the minor patient, you must present proof of guardianship, such as a court document or DCF paperwork.

For office use only. To be completed by CAAC staff

_____ _____ _____

Patient Name MR# Staff Initials