Allergy & Rheumatology Associates, LLC

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Consent for the Release of Protected Health Information to Personal Representatives

I, _____, give my written consent for Allergy & Rheumatology Associates, LLC to share information regarding my protected health information and care to the following listed persons below. I understand that these persons will be treated as personal representatives of myself.

NAME:_____ Relationship_____

NAME:_____ Relationship_____

NAME:_____ Relationship_____

NAME:_____ Relationship_____

☐ **DO NOT DISCUSS MY PROTECTED HEALTH INFORMATION WITH ANYONE OTHER THAN MYSELF AT ANY TIME.**

Patient's Signature:_____ Date:_____