HIPAA AUTHORIZATION FORM
ADVANCED ALLERGY AND ASTHMA PHYSICIANS, PLLC

NOTICE: This Form describes how medical information about you may be used and disclosed for marketing purposes and how you may obtain access to this information. Please review carefully and let us know if you have questions.

I, _____ (print name), authorize the use and disclosure of my name, likeness, photograph, video recordings and testimonials (written or video recorded) (collectively, the "Personal Information") for Advanced Allergy and Asthma Physicians, PLLC (the "Clinic") to use specifically for marketing purposes. I understand the information being disclosed pursuant to this authorization is private information and may no longer be protected by HIPAA privacy regulations. The Clinic will provide a copy of this Authorization to me upon request.

The Personal Information will be used for purposes of marketing and instructional information regarding skin testing via social media, Clinic website and other print and electronic promotional materials.

I understand that I may revoke this authorization at any time by sending written notice to the Clinic via personally delivery or registered mail. Such revocation will be effective upon receipt (i.e. it is not retroactive) and will affect future disclosures only.

I understand the Clinic cannot condition treatment on whether or not I sign this authorization.

Patient:

Signature: _____ Witness: _____
Date: _____

If patient is a minor:
Parent / Legal Guardian (print name): _____
Signature: _____
Date: _____

Advanced Allergy and Asthma Physicians, LLC
500 S. University Ave, Suite 215
Little Rock, AR 72205
(501) 420-1085