



## Allergy & Rheumatology Associates, LLC

Michelle Spuza-Milord, M.D., F.A.C.R.  
Ginige Swanthri De Silva M.D., F.A.C.R.

### 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:** \_\_\_\_\_