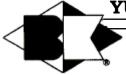
YUILL BLACK, M.D. AND MICHAEL R. KLETZ, M.D., P.C.



MICHAEL R. KLETZ, M.D., F.A.A.A.A.I., F.A.C.A.A.I., F.A.C.P. APPAJI GONDI, M.D.

DIPLOMATES AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

1420 SPRINGHILL RD., SUITE 350 MCLEAN, VA 22102 (703) 790-9722 FAX: (703) 893-8666 2021 K ST., N.W., SUITE 524 WASHINGTON, DC 20006 (202) 466-4100 FAX: (202) 296-6622 7818 DONEGAN DRIVE MANASSAS, VA 20109 (703) 361-6424 FAX: (703) 361-2472

COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Black & Kletz Allergy will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized individuals. When contacting the patient or guardian, we will not leave confidential health information on an answering machine or voicemail unless we are authorized in writing to do so. This information will also not be given to any unauthorized person who may answer your telephone (either at home or work).

I hereby consent to allow Black & Kletz, MD, PC. to reach me or leave confidential medical

information for me via: (check all that apply)	
☐ Home phone: ()	_
☐ Cell phone: ()	_
□ Work phone: ()	_
Email:@	
I authorize Black & Kletz, MD, PC. to give cor	nfidential medical information to my: (list names)
□ Spouse	Phone
□ Parents	Phone
□ Son/Daughter	Phone
□ Brother/Sister	Phone
□ Other	Phone
I acknowledge that this authorization can only	be amended or rescinded by my written authorization.
Signature Patient/Parent/Guardian	Date
Patient Name (Please Print)	Account #