

**ALLERGY ASTHMA SPECIALISTS, PA**

**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT FORM**

I have certain rights under the Health Insurance and portability & Accountability Act of 996 ("HIPAA"). The information is summarized in the boxed area below. I acknowledge that I may request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Signature Patient/ Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule can be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third party payers (insurance companies) debt collection; and conduct normal healthcare operations such as quality assessments, medication authorizations, physician certificates. I understand that I may request in writing under the **Protected Health Information (PHI)** that Allergy Asthma Specialists (AAS) restrict how my private information is used to disclose to carry out treatment, payment or healthcare operations. I understand the AAS is not required to agree to my requested restrictions, but if AAS does agree then AAS is bound to abide by them.

**For patients who bring companions to their appointments:** I understand that my private health information may be discussed at any time during any interaction between myself and the employees of AAS. It is my responsibility to exclude my companions from such conversations if I do not wish my companions to be exposed to my private information.

Our office policy is to call, text, email, patients at the numbers provided to remind them of their appointments, allergy shots, readiness of vials (allergy serum), pharmacy related issues, financial issues and general office communications as needed for continued patient care. We obtain a signed blank release for PHI so that during the course of your care with AAS (Allergy Asthma Specialist) we may receive or send medical information relevant to your care. All information is handled with care to protect your privacy. All AAS employees are bound by signed agreements to keep your PHI protected. If you have any restriction they must be submitted in writing and approved by AAS.

**Name of other person who can receive my information: (PRINT PLEASE)**

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Patient/Guardian **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print** Patient/Guardian Name \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**PERMISSION TO INVOLVE OTHERS IN PATIENT CARE**

I \_\_\_\_\_ am giving Allergy Asthma Specialists, PA my permission to involve the below listed people in my **complete medical care**. The person/people I am listing will share in my medical care. Allergy Asthma Specialist, PA can/will discuss (but not limited to) testing, treatment, results of my medical care, history, including referred to Physicians/Facilities.

This permission includes financial issues involving my care (insurance, co-pays, deductibles, personal balance, and bank charges). This is an extension of HIPAA.

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Name : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell: \_\_\_\_\_

Patient/Parent **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print** Patient Name: \_\_\_\_\_ **Acct:** \_\_\_\_\_