

Notice of Privacy Practices

Acknowledgement

I acknowledge that I have read and understand Allergy and Asthma Consultants Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Allergy and Asthma Consultants for the purpose of diagnosing or providing treatment to me, obtaining payments for my health care bills, to conduct health care operations of Allergy and Asthma Consultants, and as required by law.

I also acknowledge that I understand my rights as a patient of this practice concerning my Protected Health Information, as it is outlined in this notice. I am aware Allergy and Asthma Consultants reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority