ALLERGY ASTHMA SPECIALISTS, P.A.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided opportunity to review it.

Patient Name ______________________________ Birth Date ______________

Signature Patient/ Guardian ______________________________ Date______________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their **P**rotected **H**ealth **I**nformation (**PHI**). The individual is also provided the right to request confidential communications or that a communication of **PHI** is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Our office policy is to call patients at the numbers provided to remind them of their appointments, allergy shots, vials are ready, 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:______________________________

Patient/Guardian Signature______________________________ Date ______________

Print Name______________________________Birth Date______________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to a minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.
TPO=Treatment Payment Operations

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom/Address/Fax	(1)	Description/Purpose of Disclosure	By Whom	(2)	(3)

(1) Check this box if the disclosure is authorized.
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = E-mail; M = Mail; O = Other