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 **P**rotected **H**ealth **I**nformation (**PHI**) that Allergy Asthma Specialists (AAS) restrict how my private information is used to disclosed 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 staff 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 email or call, text 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) _____
Relationship _____

PHONE NUMBER: _____ ADDRESS: _____

Patient/Guardian **Signature**_____ Date _____

Print Patient/Guardian Name_____Birth Date_____

Information provided below, if completed properly, will constitute an adequate record of the reasonable steps taken to limit use of disclosures.
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) Initial 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 **G** = Given to Patient