ALLERGY & ASTHMA CARE OF WACO

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT RECORD OF DISCLOSURES

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

I wish to be contacted in the following manager (check all that apply):

☐ Home Telephone _____
☐ O.K. to leave a message with detailed information
☐ Leave message with call-back number only

☐ Work Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Written communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number

☐ Other (spouse, child, etc.)_____
_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate