Allergy Associates
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2650 Bahia Vista St. Suite 304
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PRIVACY PROTECTION NOTICE

_____ _____
Please Print: Patient's name Patient's date of birth

I acknowledge that I have been given an amended copy of Allergy Associate's Notice Regarding Privacy of Personal Health Information updated 9/23/13 to comply with modifications made to the HIPAA Privacy Rules to read. I understand that a copy is available upon request.

Please check the following:

Do we have your permission to:

Leave messages on your home/cell/voice mail answering machine regarding the following information?

Medical information/test results Y_____ N_____ _____
Billing information Y_____ N_____ Best Phone number to call

Leave messages at your WORK answering machine/voice mail to call our office for message?

Medical information/test results Y_____ N_____ _____
N/A _____ Best Phone number to call

Leave a detailed message with a family member who answers your phone regarding the following information?

Medical information/test results Y_____ N_____ Name of person:_____
Billing information Y_____ N_____ Phone number _____

All appointments will be confirmed, at least, the day before your appointment.

Patient signature:_____ Date:_____
Parent or guardian if patient is a minor

Relationship to patient:_____ Print name_____