Updated: 1-30-23

CONSULTANTS IN
ALLERGY & ASTHMA CARE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("**HIPAA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will 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.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received (if requested) your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact **Consultants in Allergy & Asthma Care, LLC** at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree, that you are bound to abide by such restrictions.

Patient Name: _____

Relation to patient: Self / Parent / Guardian

Parent/Guardian Name (if minor): _____

Patient Signature or Parent/Guardian (if minor):_____

Date: _____

Name(s) of other parties **allowed access** to your records:

_____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documents below:

Date: _____ Initials: _____ Reason: _____