



CONSULTANTS IN
ALLERGY & ASTHMA CARE

1160 Park Avenue West, Suite 3 South, Highland Park, Illinois 60035 office 847.432.0200 fax 847.432.0201
www.allergyasthmacare-doctor.com

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: _____ Date of Birth: _____

Relation to patient: Self Parent Legal Guardian (**check one**)

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

Parent/Guardian Name: _____

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: _____