Patient Name _____DOB_____

ELITE ALLERGY AND ASTHMA CLINIC

I understand that Under the Health Insurance Portability and Accountability act (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of any healthcare information. 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 understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that we are required to have authorization to leave a message at your home or on your answering machine, regarding appointments, labs, imaging, and billing and insurance information.

Patient Signature _____Date_____

I acknowledge that I have received a copy of the Privacy Practices for Elite Allergy and Asthma Clinic. I acknowledge receipt and have read and understand the notice of health information practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Authorized Person _____Relationship to Patient_____

Authorized Person_____Relationship to Patient_____

Authorized Person_____Relationship to Patient_____

Authorized Person_____Relationship to Patient_____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of the Privacy Practices for Elite Allergy and Asthma Clinic.

_____ _____

Patient Parent of legally authorized individual

_____ _____

Date Relationship to Patient