HIPAA ACKNOWLEDGEMENT

I,____ (patient or guardian), acknowledge that I have received a copy of Allergy & Asthma Associates – South's Notice Regarding Privacy of Personal Health Information.

_____________________ Date

______________________________ Signature

I authorize Allergy & Asthma Associates – South to release my personal health information to the following person(s) and/or organization(s):

Name	Relationship to Patient
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

I authorize Allergy & Asthma Associates – South to leave telephone messages regarding my personal health information:

- ☐ Home Phone: (___)_____-_______
- ☐ Work Phone: (___)_____-_______
- ☐ Cell Phone: (___)_____-_______
- ☐ Other: (___)_____-_______

The following is a description of my personal health information that I authorize to be used or disclosed.

____

____

____

___________________ Date

____________________________________ Signature