ELECTRONIC HEALTH RECORD CONSENT

(Please fill out all of the requested information)

Dear Patients,

Our office is in the process of becoming paperless which means all patients charts will be on an electronic health record system. All patients who wish to have access to their medical records will need to provide the office with their personal email address in order for the office to provide log in information to the patient. By law patients who are between the ages of 12-18 years old have the option to grant or deny access to their electronic records from their legal parent or guardian. All patients will be required to have their picture taken for their records whether or not they wish to have access to the EHR, as this is a requirement for all patients' charts in our practice.

◯**YES, I do wish to have access to the EHR** ◯**NO, I do not wish to have access to the EHR**

If you checked YES, please print your e-mail address: _____

_____ _____

Patient Name Printed **Signature of Patient between ages 12-18**

_____ _____

Patient/Guarantor's Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

(Please read & sign the following)

A Notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies: 1) H ow medical information about you may be used or disclosed by Allergy Consultants; 2) your rights to access your medical information, amend your medical information, request an account of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Allergy Consultants responsibilities for maintaining the privacy of your medical information.

◯**YES**, you may include my name and address in Allergy Consultants Mailing List to notify me of appointments or new office locations.

◯**NO**, you may not include me in your mailing list except for insurance billing notifications.

The undersigned certifies that he/she has read the information above, received a copy of Allergy Consultants Notice of Privacy Practices, and is the patient, or the patient's personal representative.

_____ _____

Please print Patient name or Patient's Personal Representative **Relationship (if applicable)**

_____ _____

Signature of Patient or Patient's Personal Representative **Date**

_____ _____

Office Staff Witness **If applicable, reason patient did not comply and sign**

Allergy Consultants

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