ASTHMA & ALLERGY ASSOCIATES, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Asthma & Allergy Associates, PA Notice of Privacy Practices. My signature below indicates only that I have received the Notice, not that I have read of agree with its contents.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Parent/Guardian Name (Print) Date

EMERGENCY CONTACT INFORMATION

Name(s) _____ Relationship_____

Home Phone ( )_____ Work ( )_____ Cell Phone ( )_____

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Asthma & Allergy Associates, PA to disclose the following protected health information:

Appointment Date and Times, Test Results, Account Information, Other related health information to the following people.

_____Spouse Name(s) _____

_____Parents Mother_____Father_____

_____Child Name(s)_____

_____Friend Name(s)_____

_____Other Name(s)_____

This permission will remain in effect until canceled, in writing, by the patient/guardian.

_____ _____
Date Signature of Patient/Parent/Guardian