ALLERGY & ASTHMA TREATMENT CENTER

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

Patient Name (please print): _____

I, _____, acknowledge that I have had the opportunity to read and review a copy of the Notice of Privacy Practices from Allergy & Asthma Treatment Center. I can request a copy of this notice at any time. (It is available on our website: *www.myallergytreatment.net*)

_____

Signature and Date Relationship to Patient

1. If you would like to give us permission to discuss or share medical information about you with a spouse, relative or friend, please indicate here their full name, relationship with you and any other instructions you would like to give us: _____
   _____
   _____
2. Could we leave "appointment reminders" and/or "Allergy shots reminders" messages on your answering machine/voice mail, if we cannot speak directly with you? circle: YES NO.
   Comments: _____
3. We use sign-in sheets that are HIPAA compliant to protect your identity. Please indicate if you have a preference on how you want to be addressed in the waiting room when you are called in by the staff:

☐ No specific preference

☐ _____

Comments: _____

Patient Signature:_____ Date:_____

For Office Use Only:

- Patient/ Guardian was given the opportunity to review the Notice of Privacy Practices.
- Patient/ Guardian refused to sign
- Patient/ Guardian unable to sign due to communication/language barrier
- Patient/ Guardian unable to sign due to emergency situation
- Other (Please explain):

_____
Signature of Staff