

Allergy, Asthma, Pulmonary & Internal Medicine Center

HIPAA Acknowledgement and Designation Disclosure Form

I. Acknowledgement of Practice's Notice of Privacy Practices:

By signing below, I acknowledge I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Patient Name _____ Signature _____ Date _____

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

HIPAA states your personal health information (PHI) cannot be shared unless you give consent. You have the right to have one or more persons as a personal representative and you can limit the amount of information they receive. By signing and completing below you agree AAIR may disclose your health information to the Personal Representative listed below as of the date given. This Personal Representative Designation will last until you tell AAIR otherwise. To cancel this disclosure, you will have to sign a revoke form and disclosure will cease immediately but does not cancel disclosures given while this agreement was in effect. AAIR will not cancel disclosures until signed written confirmation is received.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____

_____ OK to leave message with detailed information *Initials*

_____ Leave message with call back numbers only *Initials*

Work Telephone Number: _____

_____ OK to leave message with detailed information *Initials*

_____ Leave message with call back numbers only *Initials*

Email or Fax Communication: _____

_____ OK to fax at the number listed above

_____ E-mail me at: _____

_____ **I have read the policy and agree to be bound by all terms and conditions herein.**

_____ **Name of Patient or Responsible Party Date**

_____ **Signature of Patient or Responsible Party Date**