

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