Asthma and Allergy Associates of Florida
The Allergy Group

Authorization for Use or Disclosure of Information
Notice of Privacy Practices Acknowledgement

A Notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies: 1.) how medical information about you may be used or disclosed by AAAF 2.) your rights to access your medical information, amend your medical information, request an accounting 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.) AAAF's responsibilities for maintaining the privacy of your medical information.

Please check (initial) as appropriate, or applicable, or circle those that apply:

☐ Yes, you may include my name and address in AAAF's mailing list to notify me of appointments, changes in office hours, new office locations or new medications.

☐ No, you may not include me in your mailing list except for insurance billing notice.

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

_____ _____

Name of Patient or Patient's Personal Representative

Relationship of Personal Representative to Patient (if applicable)

_____ _____

Signature of Patient or Patient's Personal Representative

Date

_____

Signature of Witness

If applicable, reason patient's written acknowledgement could not be obtained:

_____

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Notice Dated 9/23/2013