Allergy Asthma & Immunology Relief of Charlotte
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.

_____

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **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 seize 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:** _____ **Date:** _____

Print Name: _____ **Relationship:** _____ **Date:** _____

Print Name: _____ **Relationship:** _____ **Date:** _____

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

Written Communication Address:

_____

_____ OK to mail to address listed above
Initials

_____ E-mail me at:_____
Initials

Work Telephone Number:

_____

_____ OK to leave message with detailed information
Initials

_____Leave message with call back numbers only
Initials

Fax Communication:

_____

_____ OK to fax at the number listed above
Initials

_____ E-mail me at:_____
Initials

Other: _____

I have read the policy in its entirety 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***