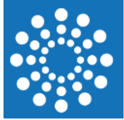

www.allergyfamilycare.com ** Practice Limited to Allergy

PRIVACY AGREEMENT

I hereby acknowledge that I received a copy of the Notice of Privacy Practices of Allergy & Asthma Family Care. I further acknowledge that a copy of the current notice will be posted in the reception areas, and that a copy of any amended Notice of Privacy Practices will be made available to me at each appointment.

Signed: ____Date: __________________________

Print Name: ____Telephone: _____________________

Relationship: (PLEASE CIRCLE ONE)

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

For Office Use Only: Date received:
Processed by:
Practice Follow-up: Yes No
Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

____

____

Reasons for refusal:

____

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