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Board Certified

Adults & Children

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Patient's Full Name | **Patient's Social Security Number**

Address, City, State, Zip Code | **Patient's Date of Birth**

Email Address | **Patient's Telephone Number**

I acknowledge that Allergy & Asthma Clinics of Ohio has offered me a copy of its Privacy Notice entitled **Your Information. Your Rights. Our Responsibilities** and that a copy of that document is available at Allergy & Asthma Clinics of Ohio. I have had the opportunity to review the document which explains how my Protected Health Information will be handled by Allergy & Asthma Clinics of Ohio.

Allergy & Asthma Clinics of Ohio asserts that theyvalue the privacy of my Protected Health Information and will do everything in their power to protect my privacy. Information regarding my care and treatment will not be given to any individual (including my spouse,my children or my significant otherormyparent(s)if I am over 18 years of age) without my written consent. If I want anyone other than my referring physician or my primary physician if I was referred by a specialist to have access to my medical information, I have listed their name and relationship to me below.

Name | **Relationship to Patient**

Name | **Relationship to Patient**

Information pertaining to my care, including reminders regarding appointments and/or immunotherapy or regarding billing issues and/or payment requirements may be left at the phone number listed above(either to the person who answers the phone or via a voice mail message)or via email at the above referenced email address. If I request that information be faxed, I authorize the staff at Allergy & Asthma Clinics of Ohio to comply with my request and understand that faxing is not the most secure method of communication and that my Protected Health Information may be available for public view.

I may revoke this authorization at any time by notifying Sandy Apicella, Practice Manager, in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual*
(The person about whom the information relates)

Date of Individual's Signature

Date of Birth or Social Security Number

Signature of Guardian*
(If the patient is a minor child)

Date of Guardian's Signature

Relationship to Patient