**Acknowledgment**

**Privacy Policy Offered**

*This is an Acknowledgment that you have been offered a copy of the Allergy, Asthma & Immunology Associates Privacy Policy, which includes, but is not limited to, information about the practice’s use and disclosure of your health information.*

* **Treatment** *(includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).*
* **Payment** *(includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and preauthorization*
* **Health Care Operations** *(includes the necessary administrative and business functions of our office)*

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| Name of person(s) whom may speak with our office staff regarding your treatment, statements and health care operations | This person relationship to you |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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We reserve the right to change our privacy practices in accordance with the law; the terms contained in the ***Policy*** may change also. A summary of the ***Policy*** will be available in the lobby of our office indicating the revised effective date in the bottom right hand corner. A copy of the ***Policy*** will be included in each new patient packet. We will offer each existing patient an initial copy of the ***Policy*** and will provide an additional copy upon request.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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| I request that Allergy, Asthma & Immunology Associates not disclose my health information to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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***I understand that it is my responsibility to read the policy I have been offered, and if I have any questions or need clarification I can contact the Privacy Officer, Carlos A. Carmona at (813) 969-0116 Ext. 2009***

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|  |  |  |  |  |
| Patient Name |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Signature of Patient or Person Authorized by Law |  | Relationship to Patient |  | Date |