Pacific Allergy & Asthma
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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your notice of privacy practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such notice of privacy practices prior to signing this consent, and acknowledge that I have studied the privacy practices prior to signing this, consent and acknowledge that I have studied the privacy practices. I understand that this organization has a right to change its notice of privacy practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the notices of privacy practices.

I understand that I may request in writing that this organization restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name:_____ **Date of Birth:**_____

Signed:_____ **Date:**_____

Who is signing and their relationship to patient (if patient is a minor):

_____