

ACKNOWLEDGEMENT

I, _____(patient), acknowledge that I have received a copy of Adult & Pediatric Asthma & Allergy Center, P.C. Notice Regarding Privacy of Personal Health Information.

Date: _____
(Patient or Guardian Signature)

.....
The following persons are permitted to receive and or discuss laboratory results, x-ray results or other information regarding medical care for:

(patient's name) _____

- 1. _____
- 2. _____
- 3. _____

Date: _____
(Patient or Guardian Signature)

(Relationship to Patient)

OR

I do not authorize any release of information

Date: _____
(Patient or Guardian Signature)

(Relationship to Patient)

.....
**Anyone over 18 years of age must sign as patient.
.....

I understand it is my responsibility to keep the office updated on any changes in my or my child's personal information.

Date: _____
(Patient or Guardian Signature)

(Relationship to Patient)