



Allergy, Asthma & Sinus Care Center

9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127
Phone 314.849.8700 | Fax 314.849.8737

HIPAA

I understand that as part of my healthcare, Allergy, Asthma, and Sinus Care Center originates and maintains health records, not limited to, describing my health history, symptoms, examination, test results, diagnoses treatment, and any plans for future care or treatment. I understand that this information is considered protected health information (PHI) and disclosure of the information will be limited to the minimum amount necessary to accomplish that stated purpose. PHI may be used to communicate with other healthcare professionals and/or third party payers.

I have been provided with the Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices at anytime. I understand that Allergy, Asthma, and Sinus Care Center reserves the right to change its practices and to make new provisions for all PHI maintained by Allergy, Asthma, and Sinus Care Center.

Authorization of release of medical information

May we leave messages on your answering machine? Home Cell Both

May we leave a message at your place of employment to call our office? Yes No

May we discuss your medical conditions with members of your family or friends who may contact the office. If you answered "yes", please complete an Authorization for Specific Use and Disclosure for Protected Health Information Form Yes No

Please list any information that you would not wish to have disclosed

This release may be rescinded in writing at any time. Allergy, Asthma, and Sinus Care Center cannot guarantee your request will be honored to the fullest. In the event of an emergency, Allergy, Asthma, and Sinus Care Center may disclose information that is related to your emergency condition.

Signature of Patient or Legal Guardian

____/____/____
Date

Signature of Allergy, Asthma, and Sinus Care Witness

____/____/____
Date