Privacy Policy and Practises Acknowledgement Form

I acknowledge I have received the policies for privacy of information from the office of Allergy Asthma Immunology Specialists and that the office is in compliance with both the Health Insurance Portability and Accountability Act (HIPAA) and Red Flag Rule (i.e. protection against personal identity theft). I understand that all information regarding the care I receive in this office will be handled according to these policies and that they conform to the guidelines set forth by the Health Insurance Portability and Accountability Act, a federal government document, as well as the Red Flag Rule, mandated by the Federal Government. I am aware that I may specify with whom my personal information be shared. I realize that my other doctors, pharmacies and my health insurance company are the customary means through which my information will be shared for my benefit.

Signature: _____ Date: _____

Full name: