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# HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

## RIGHTS REGARDING YOUR HEALTH INFORMATION

Following is a summary of your rights with respect to your protected health information as detailed in the Allergy Associates Notice of Privacy Practices provided to you. If you choose to exercise any of these rights, please complete the appropriate form at the front desk.

**Right to request special privacy protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed.

**Right to request confidential communications.** You have the right to request that you receive your health information in a specific way or at a specific location.

**Right to inspect and copy.** You have the right to inspect and copy your health information, with limited exceptions.

**Right to amend or supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete.

**Right to receive an accounting of disclosures.** You have a right to receive an accounting of disclosures of your health information made by this practice pursuant to legal requirement.

**Right to a paper or electronic copy of this Notice**. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of the Allergy Associates Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

## AGREEMENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Signature below is acknowledgement that you have reviewed the Allergy Associates Notice of Privacy Practices, obtained a personal copy as requested, and consent to our use and disclosure of your protected health information for the purposes of treatment, payment and health care operations:

Patient Name: _____

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship to Patient: _____

Patient Representative Signature: _____ Date: _____