Colorado Springs Allergy & Asthma Clinic

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Adult and Pediatric Allergy and Asthma Care

Notice of Privacy Practices-Patient Acknowledgment

We at the Colorado Springs Allergy & Asthma Clinic are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you share with us. We comply fully with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following:

Patient Name (please print): _____

Date of Birth (mm/dd/yyyy): _____

Home Phone: _____

May we leave a voice message for the patient at the home phone? YES NO

Work Phone: _____

May we leave a voice message for the patient at the work phone? YES NO

May we speak to someone else about the patient's medical care? YES NO
If yes, please list below:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

□ I would like to receive emailed updates from Colorado Springs Allergy and Asthma Clinic
□ I do not wish to receive any emails from Colorado Springs Allergy and Asthma Clinic

I have been made aware of the privacy policies of CSAAC and have received (or reviewed, or have been given the option to receive) a copy if the HIPAA Notice of Privacy Practices.

Signature:_____Date:_____

Please initial and date if the above information is accurate:

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
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