Allergy Asthma Food Allergy
CENTERS
FREEDOM FROM YOUR ALLERGIES

South County | 9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127 | Phone 314.849.8700 | Fax 314.849.8737 West County 16216 Baxter Rd. | Suite 299 | Chesterfield, MO 63017 | Phone 636.536.2600 | Fax 314.849.8700
Ste. Genevieve | 255 Boderman Ln. | Bloomsdale, MO 63267 | Phone 314.849.8700 | Fax 314.843.8737
Swansea | 510 Fullerton Rd. | Swansea, IL 62226 | Phone 618.233.8700 | Fax 314.843.8737

HIPAA

I understand that as part of my healthcare, Allergy, Asthma & Food Allergy Centers 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 & Food Allergy Centers reserves the right to change its practices and to make new provisions for all PHI maintained by Allergy, Asthma & Food Allergy Centers.

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

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This release may be rescinded in writing at any time.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

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____ _____/_____/_____
Signature of Allergy, Asthma & Food Allergy Centers Witness Date