FREEDOM ALLERGY
ALLERGY SINUS AND COUGH CENTER

Ruchir Agrawal, MD
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1255 Johnson Ferry Road, Suite 2A, Marietta, GA 30068

HIPAA Acknowledgement and Consent Forms

I. Acknowledgement of Practice's *Notice of Privacy Practices*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation will not be retroactive.

This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices as allowed by law.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

This consent was signed by:

_____ _____
Patient's Name (Printed) DOB (mm/dd/yy)

_____ _____
Signed (Patient/Legal Representative) Date

Relationship to Patient (if other than patient):_____

II. Request to Receive Confidential Communications by Alternative Means

As provided by Privacy Rule Section 164.522(b), I hereby give permission for Freedom Allergy to communicate to me about appointments, lab results, and/or patient care by phone messages, texts, email, or fax.

Phone Number:_____

Email Address:_____

Fax:_____

_____ _____

Signed (Patient/Legal Representative) Date

III. Adult Consent to Share Medical Information*

I agree that the Freedom Allergy may disclose certain pieces of my health information to a person of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. I give permission for Freedom Allergy to disclose the following information:

- ☐ Scheduling appointments
- ☐ Lab Results
- ☐ All information regarding assessment, diagnosis, and treatment of my medical condition, including oral immunotherapy, immunotherapy, and other allergic treatments.
- ☐ Other _____

The indicated information may be disclosed either phone or email to:

Name:	Relationship to Patient:	Phone #:	Email:
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Patient's Name (Printed) DOB (mm/dd/yy)

_____ _____

Patient's Signature* Date

*Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law.
*Patient can cancel this authorization in writing at any time.