Acknowledgement of Receipt of Notice of Privacy Practices;
Authorization for Practice to Utilize Information as Described in Privacy Notices;
Patient's Consent for Practice to Share Protected Health Information with Other Named Parties

The Allergy and Asthma Clinic
290 Baldwin Avenue
San Mateo, CA 94401

The Allergy and Asthma Clinic:

☐ May ☐ May Not leave a message with any other person
☐ May ☐ May Not leave detailed treatment information

☐ **Telephone:** _____

You have the right to designate a person to speak on your behalf. You must provide your health provider with the names(s) of your designated person(s) in writing.

I hereby authorize _____ (name of designate) to communicate and receive information on my behalf to/from my health care providers at the Allergy and Asthma Clinic.

I hereby give my permission to_____ (name of designate) to receive and pick-up on my behalf my immunotherapy out of office injection kits.

I hereby give permission to _____ (name of designate) to pick-up prescribed medication samples, provided by my health provider at The Allergy and Asthma Clinic.

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Name of Patient:_____