



Allergy and Asthma Associates, P.C.

Sharon Seth, MD

Courtney J. Blair, MD

Bridget Schaefer, PA-C

RECEIPT OF PRIVACY PRACTICE STATEMENT

By signing this acknowledgement, I am acknowledging that Allergy and Asthma Associates, P.C. have made available to me their Notice of Privacy Practices that provides a description of healthcare information and uses. **This document will stay in effect until updated by patient/guardian or once patient is 18/yr.**

Please print your name and sign and date this acknowledgement and return to the receptionist.

■ Excluding myself (if minor child, the child's parents or legal guardian), I give my permission for my medical records, including scheduled appointments and/or financial information to be discussed with the following individual(s)

(please check) ☐ Medical information and/or ☐ Financial information

1. _____
Name Relationship

2. _____
Name Relationship

■ Financial statements for my account **should be mailed to:** (Please notify staff if different than the one on file)

Name Relationship

Patient's Name: _____ Date of Birth: _____

Signature: _____ (parents signature if patient is a minor)

Printed Name: _____ Date signed: _____

FOR OFFICE USE ONLY

Acknowledgement received by _____ and added to patients chart on _____.