# NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

## Acknowledgement of Receipt of Notice of Privacy Practices

I have received Fort Wayne Allergy and Asthma Consultants' Notice of Privacy Practices and understand that my protected health information may be used by this practice as described in the notice.

Patient Name: _____

Patient Date of Birth: _____

I hereby authorize Fort Wayne Allergy and Asthma Consultants, Inc. to disclose my protected health information to (List anyone, other than physicians, hospitals, legal guardians):

_____

_____

_____

_____

_____

This authorization shall remain in effect indefinitely unless specifically amended by the patient or legal guardian.

Please print your name here: _____

Signed (patient or legal guardian): _____

Today's Date: _____