Patient Name:_____ Date:_____
(please print patient's name)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

BERKSHIRE ALLERGY & ASTHMA CENTER, INC.

I, _____ acknowledge that I have
(Patient's Name or Parent/Guardian if child)
received a copy of the practice's Notice Regarding Privacy of Personal Health Information.

AUTHORIZATION for USE or DISCLOSURE of INFORMATION

I, _____hereby authorize Berkshire
(Patient's Name or Parent/Guardian if child)
Allergy & Asthma Center to release protected health information to (please list name of person(s) who is entitled to receive your protected health information and their relationship to you):

Name(s):_____ Relationship to Patient_____

Name(s):_____ Relationship to Patient_____

Name(s):_____ Relationship to Patient_____

Please indicate all the ways you are allowing us to reach this person(s):

_____Telephone _____Cell Phone _____Answering Machine

_____Fax _____Mail

Are there any limitations to personal health information you allow to be disclosed to these individuals? If so, please specify:

This authorization will remain in effect until you specify otherwise.

Patient's/Guardian's Signature:_____