

ACKNOWLEDGEMENT

I, _____ (patient, parent or legal guardian),
acknowledge that I have received a copy of Cincinnati Allergy & Asthma Center's
"Notice Regarding Privacy of Personal Information."

DISCLOSURE TO FAMILY/FRIENDS

I HEREBY AUTHORIZE CINCINNATI ALLERGY AND ASTHMA CENTER, INC. TO DISCUSS
THE FOLLOWING WITH THE PERSON/PERSONS LISTED BELOW:

- YES / NO CONDITION/TREATMENT/PLAN OF CARE
- YES / NO DIAGNOSTIC/LAB TEST RESULTS
- YES / NO PHOTOGRAPHS TAKEN IN OFFICE OF SKIN DISORDER/EYE SYMPTOMS/ETC.
- YES / NO BILLING INQUIRIES
- YES / NO PERMISSION TO LEAVE MESSAGES/TEST RESULTS ON
VOICE MAIL/ANSWERING MACHINE

ALLOWED PERSON/PERSONS: (ie: spouse, step-parents, grandparents, etc):

<u>NAME</u>	<u>RELATION</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(* NOTE IF PATIENT IS 18 YEARS OR OLDER THEY ARE CONSIDERED AN ADULT)

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE _____ DATE _____

***This form is necessary for the Health Insurance Portability
and Accountability Act enforced by the Federal Government.***