



# The Allergy & Asthma Group, P.C.

## PRIVACY POLICY

New federal regulations require physician practices to keep your medical information private. The Allergy & Asthma Group, P. C. has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. (As a component of our teaching function, we occasionally have medical residents or pharmaceutical representatives accompanying our physicians. They will be identified to you, and your approval will be sought. If you object to their presence, please let a member of your clinical team know.) If anyone else helps us with our internal operations, we will require them to keep any patient information they may see confidential. **All other releases of information have to be specifically authorized by you.** If you ask us to account for these releases of information, we will do so. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and at least seven years after your last visit. We may occasionally send you information on new procedures and products that we offer.

I acknowledge that I have been informed about the privacy of my medical record. \_\_\_YES \_\_\_NO

### RELEASE OF MEDICAL INFORMATION

The general policy of The Allergy & Asthma Group, P. C. is to release medical information only to patients and guardians. If you, the patient (or guardian), would like information to be released to anyone else (such as a spouse, parent, or close friend), you can identify other individuals in the section below. **We cannot release information, even to a spouse or parent, unless we have permission to do so.** (You can modify this form at any time by adding or deleting the names of individuals who have access to your information.)

- Spouse: \_\_\_\_\_
- Child(ren): \_\_\_\_\_
- Other (state relationship): \_\_\_\_\_

\_\_\_\_\_  
Patient name (please print)                      Patient (or Guardian) Signature                      Date

Please tell us the ways we can contact you.

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

**May we leave messages regarding:**    **Appointments (Yes / No)?**    **Test results (Yes / No)?**  
**Other Clinical Updates (Yes / No)?**

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