APEXALLERGY

PATIENT PRIVACY FORM

PATIENT INFORMATION

Patient's First Name | Patient's Last Name | Date of Birth

SHARING INFORMATION & ACCESS

Please list who has permission to receive information, schedule appointments and attend appointments aside from the patient and the patient's parents/legal guardians.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Listed persons above have permission/access to:

☐ Lab/X-Ray Results ☐ Medical Information ☐ Billing Information ☐ Proxy Access to Online Portal

☐ Appointment Information ☐ Schedule Appointments ☐ Bring Minor Patient (Under age of 18) to Appointment

COMMUNICATION

I authorize Apex Allergy & Immunology to leave voice messages regarding: Check ONLY ONE

◯ All Information including appointments, general information, updates, billing, etc.

◯ Appointment Information ONLY

On the following voicemail(s): *Check ALL that apply.* ☐ Cell Phone Number ☐ Home Phone Number

☐ **I authorize Apex Allergy & Immunology to send me important updates via SMS/Text (Message and data rates may apply)**

☐ **I authorize Apex Allergy & Immunology to email me important updates**

I understand that I have the right to revoke this authorization at any time by sending notification to Apex Allergy & Immunology 534 Woods Lake Road, Greenville, SC 29607. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to: Apex Allergy & Immunology 534 Woods Lake Road, Greenville, SC 29607. I understand that I have the right to refuse to sign this authorization.

_____ _____ _____

Signature | Date | Relationship to Patient