Patient Privacy Form

APEXALLERGY

Date

PATIENT INFORMATION

Patient's Name

Date of Birth

SHARING INFORMATION

Please list who has permission to receive information other than the patient and the patient's parents/legal guardians.

Name of person that has permission to receive the above patient information

Relationship to patient

Name of person that has permission to receive the above patient information

Relationship to patient

BRINGING PATIENT TO THE DOCTOR *(if patient is under 18)*

List anyone who has permission to bring the above patient to the doctor other than the patient's parents/legal guardians.

Name of person

Relationship to patient

Name of person

Relationship to patient

COMMUNICATION

I authorize Apex Allergy & Immunology to leave a message regarding: *Check ONLY ONE*

- ☐ All Information including appointments, general information, updates, billing, etc.
- ☐ Appointment Information ONLY

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

I would like to receive text messages when my prescriptions have been sent to the pharmacy. ☐ Yes ☐ No

RIGHTS OF THE PATIENT

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.

I have read and received a copy of the Notice of Privacy Practices for Apex Allergy & Immunology.

Signature

Date

Self/Relationship to patient