The Virginia Center for Allergy & Asthma

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PRIVACY NOTICE/DISCLOSURE STATEMENT

In general, HIPAA (Health Insurance and Portability and Accountability Act) gives patients the right to request restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communication or that communication of PHI is made via alternative means, such as sending correspondence to the patient's office instead of the patient's home.

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of and requests fro PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient or legal representative of said patient. This includes requests made by other physicians and their offices. Our office will supply the proper form. Note: Uses and disclosures for PHI may be permitted without prior consent in the event of an emergency. All authorizations will be in effect until revoked in writing by the patient or legal representative of the patient.

Contact Preference:

I prefer to be contacted regarding my PHI in the following manner (please check all that apply):

- □ Home Phone # : ________________________________
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.
- □ Cell Phone #: ________________________________
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.
- □ Work Phone #:________________________________
  - □ Please leave a detailed message.
  - □ Please only leave a message with a callback number.

For children/patients less than 18 years old:

- □ I authorize The Virginia Center for Allergy and Asthma to discuss all pertinent medical information with the parent(s)/legal guardian(s) of the child.
- □ I do NOT authorize The Virginia Center for Allergy and Asthma to discuss all pertinent medical information with the parent(s)/legal guardian(s) of the child.

Disclosure Information:

I authorize The Virginia Center for Allergy and Asthma to disclose or provide any and all protected PHI to:

Name: ____ Phone #: ________________________

Relationship: ____________________________________

Signatures:

____ ______________________________

Patient/Parent/Legal Guardian Date

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Printed Name of Above Signature