**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Notice of Privacy Practices B”H

**Please read and sign below. By signing, you acknowledge that you have read and understand the Notice of Privacy Practices.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Confidentiality.**  It is the policy of Advancements in Allergy and Asthma Care, Ltd. (“AAAC”) to protect the privacy and confidentiality of patients’ medical information and to comply with the Health Insurance Portability and Accountability Act (HIPAA).

**Notice of Privacy Practice.** AAAC’s Notice of Privacy Practices explains how AAAC may use and disclose my medical information. It also explains my rights regarding this kind of information. AAAC may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices upon request. AAAC’s Notice of Privacy Practices can be obtained by contacting the clinic.

Signature of Patient (or legal guardian): Date: