

# ALLERGY & RHEUMATOLOGY MEDICAL CLINIC, INC.

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

PLEASE PRINT

I, \_\_\_\_\_, have reviewed a copy of **Allergy & Rheumatology Medical Clinic, Inc.'s** Notice of Privacy Practices. I am aware that at my request, I can receive one.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

ARMC is authorized to release medical information to the following individuals. It is my responsibility to update ARMC to any changes in this list.

Yes \_\_\_\_\_ No \_\_\_\_\_ Physicians associated with my care

Yes \_\_\_\_\_ No \_\_\_\_\_ Spouse

Yes \_\_\_\_\_ No \_\_\_\_\_ Son/Daughter (print name) \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ All family members

Yes \_\_\_\_\_ No \_\_\_\_\_ Tests results and messages may be left on my recorder/voicemail

Other individuals authorized to receive information regarding my medical care:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_