HIPAA Privacy Notice – Patient Acknowledgement
"Health Insurance Portability and Accountability Act"

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical record of your care remains the physical property of Colorado Allergy and Asthma Centers, P.C. The State of Colorado supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as; physician, medical practice, or to an insurance company for treatment, payment, and operations of CAAC.

Health Care Operations

There remain certain operational activities, where, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific occurrence by you. Some examples include:

- Requesting Photo ID at your visit
- Taking and saving a photograph of the patient for the chart to be used for identification and medical treatment
- Calling / faxing / electronically communicating to your pharmacy for prescription authorization
- Calling your insurance carrier for billing and/or reimbursement purposes
- Faxing / mailing your insurance carrier documentation of care
- Calling / faxing / e-mailing your Primary Care Physician (PCP) with results of care or questions
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office / reception staff call, text, or email you to schedule an appointment, acquire a referral, or to inform you about medications that may have to be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as lab or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours
- Discussing an opportunity to enroll you in ongoing Asthma Allergy Research; and/ or continuation in research studies/ clinical trials
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State or by Court Order. Please note that any unsecure electronic communication initiated by the patient/family is done so at their own risk

Your Rights under the Law:

You have the right to receive a notice about our privacy policy

The right to inspect your protected health information (PHI) with a provider in a private environment

The right to request a copy of PHI and to have returned to you in 30 days, unless notified in writing of 60-day return

The right to request a restriction on uses and disclosures of your protected health information

The right to request to receive confidential communications from the practice by alternative means or at an alternative location

The right to request an amendment of your protected health information

The right to request an accounting of disclosures of Protected Health Information (PHI)

The right to revoke or limit authorization

The right to be notified of a breach of your PHI

Please list by name and relation the person(s) that may receive messages or talk to us regarding patient's medical care.

______________________________	______________________________
Name/relation	Contact Number
______________________________	______________________________
Name/relation	Contact Number
______________________________	______________________________
Name/relation	Contact Number

Practice Duties

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

Patient Name (label) ____

ACKNOWLEDGEMENT

I, ________________________________ (patient, responsible party), acknowledge that I have received a copy of Colorado Allergy and Asthma Centers P.C.'s (the practice's) "HIPAA Privacy Notice-Patient Acknowledgment" document regarding protection of Personal Health Information (PHI).

Patient's or Responsible Party's Signature ___________________________ Date ____________

You may request at any time a detailed written policy of the Colorado Allergy and Asthma Center's P.C., "HIPAA Privacy Notice- Detailed" or access it at www.coloradoallergy.com