Advanced Allergy & Asthma
Dr. Melissa Graham and Associates

500 S University Ave, Ste 215
Little Rock, AR 72205
501-420-1085: phone
501-420-1457: fax

Acknowledgment of Privacy Practices

Patient name: _____ Date of Birth: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Advanced Allergy and Asthma.

In the section below, please fill out the names of anyone you want to be able to contact our office regarding your treatment, appointments, prescriptions, etc, OR check the box indicating that no one has permission to contact our office regarding you.

☐ **Yes,** I am giving permission to the below individual(s) to have access to my protected health information about myself/patient, and I understand that I may revoke this permission in writing at any time.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ **No,** I do not want to give anyone permission to discuss or obtain protected health information other than other physicians and medical facilities at this time.

_____ _____

Patient Signature (or Parent/Guardian, if patient is minor) Today's Date