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. _____