MASA
MIDWEST ALLERGY SINUS ASTHMA sc

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I, _____, hereby acknowledge receipt of the physician's Notice of
(Patient's Name)
Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.
I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available our website at ***www.asthma2.com***.

I wish to be contacted in the following manner (check all that apply).

Home: Phone: _____	**Work**: Phone: _____
❑ OK to leave message with detailed information	❑ OK to leave message with detailed information
❑ Leave message with call back number only	❑ Leave message with call back number only
❑ OK to fax home: _____	❑ OK to fax work _____
❑ OK to mail my home address	❑ OK to mail my work address

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Midwest Allergy Sinus Asthma, SC may disclose my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to such. In that case, Midwest Allergy Sinus Asthma, SC will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I designate the following persons listed below as persons involved in my health care or payment relating to such. For the purpose of Midwest Allergy Sinus Asthma, SC making the limited disclosures described above. (*I understand that I am not required to list anyone and that I may change this list at any time in writing.*)

Print Name of each designated person below:	Date of birth:

Patient Signature: _____Date: _____

If you are not the patient, please specify your relationship to the patient _____.