

**Family Allergy, Asthma, Immunology, & Sinus Center P.C.**

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HIPPA Notice of Privacy Practices - Acknowledgement of Receipt

**Family Allergy, Asthma, Immunology, & Sinus Center P.C.**

Nerin Magana, Office Manager

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I hereby acknowledge that I was offered a copy of this medical practice's Notice of Privacy Practices. I acknowledge that a copy of this practice's Notice of Privacy Practice is available upon my request. I further acknowledge that a copy of any amended Notice of Privacy Practice will be available at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient (if not signed by patient):

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