

**NOTICE REGARDING PRIVACY OF PERSONAL HEALTH
INFORMATION
FOR WESTSIDE ALLERGY CARE, PC (“the practice”)**

**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.**

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient’s Name (print)

Patient’s Signature

Date

Authorized Facility Signature

Date