Food Allergy Center of Florida
Windom Allergy, Asthma & Sinus
Sarasota Clinical Research

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Acknowledgement of Notice of Privacy Practices & Consent for Communication and/or Disclosure

Patient Name: _____ **Date of Birth:** _____

I have received this practice's Notice of Privacy Policy written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Policy, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I understand the office enrolls interested patients in Clinical Trials of new medications. If my medical record indicates that I may quality for participation, I may be contacted with information about the study.

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

- ☐ Cell Phone (_____)_____-_____
- ☐ Home Phone (_____)_____-_____
- ☐ Work Phone (_____)_____-_____
- ☐ Email Email Address: _____

I give my permission to share information with the person(s) names below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____