



JOHN V. BOSSO, MD, FAAAAI, FACAAI,  
 LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

**PATIENT REGISTRATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

How did you hear of us? \_\_\_\_\_

**INSURANCE INFORMATION**

Primary	Secondary
Insurance Company:	
Address:	
ID #:	
Group #:	
Policy Holder's Name	
Policy Holders Address:	
Policy Holder's Relationship to Patient:	
Policy Holder's D.O.B.	
Policy Holder's SSN:	
Policy Holder's Employer:	
Policy Holder's Work Phone:	

I hereby authorize release of any information required to process insurance claims related to services rendered by this office.

\*\* Signature: \_\_\_\_\_ Date: \_\_\_\_\_



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

## PATIENT INSURANCE WAIVER

I \_\_\_\_\_ have requested treatment from the Allergy & Asthma Consultants. I agree that I am responsible for all charges incurred for any visit. I understand I will be responsible for payment **if:**

- I am not insured with a participating insurance plan
- I do not provide the necessary insurance referral from my PCP on the day of my visit, if required by my plan.
- I do not provide the correct insurance information to the office
- My insurance plan has been canceled
- My insurance does not cover the services rendered
- If I don't comply with my insurance co. request for information (as an example, full time student status, other insurance information )

I am aware that some insurance companies might not cover Nasal Smears and Rhinometry tests. Therefore, I have agreed before receiving the service to pay for it myself.

Patient Signature \_\_\_\_\_ DATE \_\_\_\_\_

### Authorization Of Payment

I hereby authorize payment for all medical benefits directly to Allergy & Asthma Consultants Of Rockland & Bergen P.C. (P.A.)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



**ALLERGY & ASTHMA  
CONSULTANTS  
OF ROCKLAND & BERGEN**

JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

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**Patient Name**

**Date**

If you have been referred to our practice by another physician(s), please provide us with the information below in order to help insure effective communication. We thank you in advance.

Physician's Name  
Address  
City, State & Zip  
Phone Number  
Fax Number  
Specialty

Physician's Name  
Address  
City, State & Zip  
Phone Number  
Fax Number  
Specialty



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACEP, FAAAAI

**ACKNOWLEDGEMENT**

I, \_\_\_\_\_ (patient), acknowledge that I have received a copy of Allergy and Asthma Consultants of Rockland and Bergen's Notice Regarding Privacy of Personal Health Information.

Please give us the names of people/family members whom we may discuss/release any laboratory or test results with:

1. \_\_\_\_\_ Relationship \_\_\_\_\_
2. \_\_\_\_\_ Relationship \_\_\_\_\_
3. \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

Allergy & Asthma Consultants 1  
 of Rockland and Bergen  
 John V. Bosso, M.D., FAAAAI, FAAAAI  
 Lourdes B. de Asis, M.D., FACP, FAAAAI

**ALLERGY, ASTHMA, AND IMMUNOLOGY REVIEW**

Antihistamine medications (Claritin, Clarinex, Zyrtec, Allegra, Benadryl, Atarax, Contac, Tylenol PM or Allergy, etc.) may interfere with skin tests for specific allergies; each antihistamine has a specific time frame for which it needs to be discontinued prior to skin testing. The office nursing staff can assist you with this.

Please answer all questions on all 6 pages to the best of your ability. Base your answers on your own observations and not on what you have been told by others or what you may have presumed on the basis of previous allergy tests. Complete the questionnaire before you see the physician as the information will organize your thinking and facilitate understanding of your case. If a question does not apply, you may leave it blank.

I. Describe in your own words your problem(s) which might reflect an allergic/ exaggerated reaction \_\_\_\_\_

II. Please put a check and complete the blanks which apply to your symptoms:

	Present Problem	Past Problem	MD Comment:
A. Eye Symptoms (Wears contact lenses <input type="checkbox"/> )			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Watering	<input type="checkbox"/>	<input type="checkbox"/>	
Redness	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
B. Symptoms in the upper respiratory tract (nose, sinuses, throat, Eustachian tubes, voice box: )			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	
Congestion	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	
Drainage	<input type="checkbox"/>	<input type="checkbox"/>	
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Polyps	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired Smell/ Taste	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	
C. Symptoms in the lower respiratory tract (windpipe, bronchi, lungs):			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Sputum production	<input type="checkbox"/>	<input type="checkbox"/>	
Tightness- Congestion	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	

Name: \_\_\_\_\_

Allergy & Asthma Consultants  
of Rockland and Bergen

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How many ordinary colds and "flu" illnesses have you had in the last year? # \_\_\_\_\_

How many colds and "flu" on average in the last 5 years? # \_\_\_\_\_ / yr.

What proportion (0, 10, 25, 50, 75, 90, 100%) of these are complicated by:

Otitis-earache, decreased hearing \_\_\_\_\_%, Sinusitis- pressure discolored drainage- \_\_\_\_\_%;

Bronchitis- cough with discolored sputum \_\_\_\_\_%; Asthma- chest tightness,  
Wheeziness \_\_\_\_\_%

What proportion require antibiotics for resolution? \_\_\_\_\_%

Which antibiotic(s) work(s) best for you? \_\_\_\_\_

D. Symptoms in the stomach and digestive system which you suspect might be allergic:

	<u>Present Problem</u>	<u>Past Problem</u>	<u>MD Comment:</u>
Pain or difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn/ Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation/ Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
E. Hives/ Giant Swelling?	<input type="checkbox"/>	<input type="checkbox"/>	
F. Eczema?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Skin reaction to poison ivy/ oak, Metals, chemicals, or cosmetics? (Circle)	<input type="checkbox"/>	<input type="checkbox"/>	
H. Reaction to bee, hornet, wasp, Yellow jacket, or other stinging Insect bite? (Circle)	<input type="checkbox"/>	<input type="checkbox"/>	
I. Reaction to immunization?	<input type="checkbox"/>	<input type="checkbox"/>	
J. Reaction(s) to drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin (Date/ year last taken)	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin (date/ year last taken)	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	
Nose drops/ sprays	<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	
Pain relievers	<input type="checkbox"/>	<input type="checkbox"/>	
Hormones	<input type="checkbox"/>	<input type="checkbox"/>	
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone	<input type="checkbox"/>	<input type="checkbox"/>	
X-ray dye	<input type="checkbox"/>	<input type="checkbox"/>	
Others _____	<input type="checkbox"/>	<input type="checkbox"/>	
K. Latex reactions? (gloves, balloons, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	





Name: \_\_\_\_\_

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V. Complete the blanks or check the characteristics to describe yourself: (Social History)

Single     Married     Divorced     Widowed

# of days of work/ school missed in past year? \_\_\_\_\_ # of practitioners seen in past year? \_\_\_\_\_

# of emergency room/ urgent care visits in past year? \_\_\_\_\_ # of days in hospital in past year? \_\_\_\_\_

Aerobic exercise type? \_\_\_\_\_ Hours per week? \_\_\_\_\_

Average hours of sleep per night when well? \_\_\_\_\_ when ill? \_\_\_\_\_

Packs of cigarettes smoked per day? \_\_\_\_\_ other tobacco per week? \_\_\_\_\_

If former smoker: years quit? \_\_\_\_\_ Smoked total # years \_\_\_\_\_ Average #packs/day \_\_\_\_\_

Bottles of beer per week \_\_\_\_\_ #alcoholic drinks per week \_\_\_\_\_

Hobbies \_\_\_\_\_

Drug Use:  Never    If Yes;  in past     current    Type/ frequency: \_\_\_\_\_

Tendency to worry/ anxiety/ panic:     strong     average     little

Tendency to depression     strong     average     little

VI. Family History of Allergy / Asthma

	Eyes	Nose/ Sinuses	Chest (asthma)	Digestive	Hives/ Swelling	Eczema
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. Treatment

	Received	Helpful	Side Effects
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine by mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants by mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal sprays/ drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral bronchodilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhaled bronchial medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollen, mold, dust injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids (Circle: nose/ pills/			
Bronchial/ injection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIII. Year of last immunization for influenza? \_\_\_\_\_ pneumonia? \_\_\_\_\_ tetanus? \_\_\_\_\_





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**PATIENT INSTRUCTION SHEET FOR  
AEROALLERGEN & FOOD ALLERGY SKIN TESTING**

You will be skin tested to important local airborne allergens and/or food allergens. These may include trees, grasses, weeds, molds, dust mites, and danders (and/or foods such as milk, egg, peanut and some others). The skin tests generally take approximately 60 minutes. Puncture tests will be performed on your back and intradermal tests on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy hive (caused by histamine release into the skin) will appear on your skin within 15 – 20 minutes. These positive reactions will gradually disappear over a period of 30 – 60 minutes, and typically, no treatment is necessary for this itchiness. Local swelling at a test site (which itches occasionally) begins 4 to 8 hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. If they are bothersome, please call the office for instructions on local treatment.

**DO NOT:**

1. Over the counter antihistamines should not be used 2 – 4 days prior to the scheduled skin testing. Refer to the table on the next page for specific medication and withholding time. These include cold tablets, sinus tablets, hay fever medications, or treatments for itchy skin. Some of the names of these drugs include Actifed, Drixoral, Dimetapp, Benadryl, Tavist, Trinalin, Periactin, Tylenol PM or Tylenol PM Allergy Sinus medications stating PM and many others. If you have any questions, whether or not you are using an antihistamine, please ask the nurse or doctor.
2. Medications such as over-the-counter sleeping medicines (e.g. Nytol) and other prescribed drugs such as amitriptyline hydrochloride (Elavil), hydroxyzine (Atarax/Vistaril), doxepin (Sinequan) and imipramine (tofranil) have antihistaminic activity and should be discontinued at least **two weeks prior** to skin tests.
3. If you are taking a prescription antihistamine (Allegra, Clarinex, Zyrtec, Xyzal etc.), refer to the table on the next page.
4. Patients on Astelin, Asetpro, or Patanase nasal sprays should not use these medications for 48 hours prior to the tests.



**YOU MAY:**

1. Continue on your intranasal allergy sprays such as Flonase, Nasalcort, Beconase, Rhinocort, Nasonex, Nasalcrom, Vancenase or Nasarel. Entex or Sudafed may also be used temporarily but not on the day of testing.
2. Most drugs do not interfere with skin testing but make certain that your physician or nurse knows about every drug you are taking.

After skin testing, you will meet with the doctor (either the same day or possibly another day) who will make further recommendations regarding your treatment.

**\*\*We request that you do not bring small children with you when you are scheduled for skin testing, unless they are accompanied by another adult who can sit with them in the waiting room. Please do not cancel your appointment since the time set aside for your skin test is exclusively yours. If for any reason you need to change your appointment, please give us at least 48 hours notice. Due to the length of time scheduled for skin testing, a last minute change results in loss of valuable time that another patient might have utilized. We thank you for your cooperation.\*\***



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**EFFECTS OF ANTIHISTIMINES ON ALLERGY SKIN TESTS**

Antihistimines taken orally can block responses to immediate-type allergy skin tests. Below is a list of some commonly used antihistamines and the approximate amount of time that these medications must be withheld prior to immediate hypersensitivity allergy skin tests:

**MEDICATIONS**

**AMOUNT OF TIME**

1. Benadryl/Tylenol Allergy & Sinus or PM	24 – 48 hours
2. Chlortrimeton (chlorpheniramine Short-act) 4mg	24 – 48 hours
3. Chlortrimeton 12 mg (12 hour)	3 – 4 days
4. Tavist (clemastine)	4 days
5. Claritin/Claritin D-24/Redi-tabs (loratadine)/Alavert	10 days
6. Claritin D-12 hour, Clarinex 5 mg	7 days
7. Allegra (fexofenadine) 60 mg/Allegra D-12 hour	3 days
8. Allegra (fexofenadine) 180 mg	5 days
9. Zyrtec (cetirizine)	3 – 4 days
10. Xyzal (levocetirizine)	7 days
11. Astelin, Patanase, or Astepro <u>Nasal Sprays</u>	48 hours
12. Atarax/Vistaril (hydroxyzine)	10 days
13. Periactin (cyproheptadine)	72 hours
14. Tricyclic antidepressants (Elavil, Amitryptiline, Nortriptyline)	10 – 14 days

**For information on other antihistamines or medications, please feel free to contact the office at (845) 353-9600.**

**Notice Regarding Privacy of Personal Health Information**

**NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION**

For Allergy and Asthma Consultants of Rockland and Bergen ("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.**

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practice's duties and controls

information.

**I. Protected Health Information**

"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

**II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations**

Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

**Treatment.** The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots, which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

**Payment.** When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose you protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose you protected health information to your insurance company to obtain payment.

**Operations.** The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

**Other Uses and Disclosures.** As part of treatment, payment, and healthcare operations, the practice may also use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

**11. Additional Uses and Disclosures Permitted Without Authorization or An Opportunity to Object**

In addition to treatment, payment, and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

**When Legally Required.** The practice will comply with any Federal, state or local law that requires it to disclose your protected health information.

**When There Are Risks to Public Health.** The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:

- (1) Prevent, control, or report disease, injury, or disability;
- (2) Report vital events such as birth or death;
- (3) Conduct public health surveillance, investigations, and interventions;
- (4) Collect or report adverse events and product defects; track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;
- (5) Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
- (6) Report to an employer information about an individual who is a member of the workforce.

**To Report Abuse, Neglect Or Domestic Violence.** As required or authorized by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence.

**To Conduct Health Oversight Activities.** The practice may disclose your protected health information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

**For Judicial And Administrative Proceedings.** The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal is expressly authorized by such order or a signed authorization is provided.

**For Law Enforcement Purposes.** The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

- (1) Required by law to report of certain types of physical injuries;
- (2) Required by court order, court-ordered warrant, subpoenas, summonses, or similar process;
- (3) Needed to identify or locate a suspect, fugitive, material witness, or missing person;
- (4) Needed to report a crime in an emergency situation.

You are the victim of a crime in specific limited instances; and

Your death is suspected by the practice to be the result of criminal conduct.

**To Coroners, Funeral Directors, and/or Organ Donors.** The practice may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

**For Research Purposes.** The practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information.

To Prevent or Diminish A Serious and Imminent Threat To Health Or Safety. If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct.

For Specified Government Functions. As authorized by the HIPAA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military or veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

### III. Uses and Disclosures Permitted With An Opportunity to Object

Subject to your objection, the practice may disclose your protected health information (1) to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care, then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

### IV. Uses and Disclosures Authorized by You

Other than the circumstances described above, the practice will not

disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

### V. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

*The right to inspect and copy your protected health information.* For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the practice uses to make decisions regarding the services provided to you. The practice may deny your request to inspect or copy your protected health information if the practice determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:

(1) information compiled in reasonable anticipation of, or for use in, a civil,

criminal, or administrative action or proceedings and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the practice's Privacy Officer to inspect and copy your health information. The practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the practice in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record at the number given on the last pages of this Notice.

*The right to request a restriction on uses and disclosures of your protected health information.* You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer.

The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

*The right to request to receive confidential communications from the practice by alternative means or at an alternative location.* You have the right to request that the practice communicate with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the practice's Privacy Officer.

*The right to request an amendment of your protected health information.* During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practice's Privacy Officer. Your written request must supply a reason to support the requested amendments.

*The right to request an accounting of certain disclosures.* You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment or health care operations as described in this Notice. The practice is not required to account for disclosures (1) which you authorized, (2) which you authorized by signing an authorization form, (3) for a facility directory, (4) to friends or family members involved in your care, and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six-year period. The practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance of the request.

*The right to obtain a paper copy of this Notice.* The practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

### VI. The Practice's Duties

The practice is required to ensure the privacy of your health information

and to provide you with this Notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this Notice, as may be amended periodically. The practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters its Notice, the practice will provide a copy of the revised Notice through regular mail or in-person contact.

### VII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

### VIII. Contact Person

The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

Allergy and Asthma Consultants of Rockland and Bergen

2 Crossfield Ave. Suite #406 West Nyack, NY 10994 ATTN: Privacy Officer The Privacy Officer can be contacted by telephone at (845) 353-9600 or at (201) 666-8500.

### X. Effective Date

This Notice is effective on April 14, 2003.