**Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice**

ASTS is required by federal law to protect your healthcare information – ASTS will never share your protected health information without your consent, even to family members.

Please list up to three people with whom ASTS may share information (You are not required to list any names, although we recommend at least one person).

**Name & Relationship to Patient**

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

Please read ASTS’ *Notice of Information Practices* (located at the front desk) for more information regarding your protected rights under HIPAA.

Please notify an ASTS employee if, at any time, you would like a personal copy of any medical records or related documents.

**By signing below, you acknowledge that you have read and understand all information provided to you by ASTS.**

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*Printed Name DOB*

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*Signature* *Date*