



A Medical Corporation

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Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Officer Rosa Myers 408 286-1707

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Confidential Channel Communication Record

As required by the Health information Portability and Accountability Act of 1996, you have a right to request that communications concerning personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contract must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supercedes any prior request for confidential channel communication I may have made.

Please select:

Phone

Other _____

Print Name: _____

Telephone: (____) _____

Signed: _____

Date: _____

If not signed by the patient, please indicate relationship: _____

Patient's Name: _____

Address _____