OPEN CARE DISCLOSURE

Patient Authorization regarding allergy clearing work being provided in an "open care" environment:

It is the practice of this office to provide Allergy Clearing Technique (ACT) care in an "open care" environment. "Open care" involves several patients of a family or friends being seen in the same room at the same time with the doors remaining open. Patients are within sight or earshot of one another and some ongoing routine details of care are discussed within earshot of other patients and staff.

This environment is used for ongoing care and is the environment used for taking patient histories, performing examinations or presenting reports of findings. New patient exams are scheduled with the intent of no other patients being in the office at the same time, but this cannot be guaranteed. These procedures can be completed in the same room with the door closed but does not guarantee that information could not be incidentally overheard. Doors remain open in our office unless the patient explicitly requests the door be closed and only for a brief time to relay personal information.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open care" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

If you choose not to be seen in an "open care" environment, other arrangements will be made for you within the limitations of our office or a referral to another ACT provider. Your decision will have no adverse effect on your care from us, as a provider or on your relationship with our staff. Your signature indicates your authorization of this activity.

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

_____ _____

Name (printed) **Signature** **Date**

Approval expires at 7 years from disclosure or in continuum as long as patient has an active file in the office.
Effective 10/01/2017