Allergy & Asthma Center of Southern Oregon, PC
Crisor, LLC c/o Clinical Research Institute of Southern Oregon, Inc.
3860 Crater Lake Avenue, Medford, OR 97504
Phone: (541) 858-1003 Fax: (541) 857-4499

Summary Notice of Privacy Practices**

Dear Patient,

This letter is to provide you a brief summary of our privacy policies. Please take a moment to read through this information. This is provided to continue to serve your medical needs and to comply with federal and state medical privacy rules.

As a patient of our clinics, certain information about you will be collected and kept on file at our office. This information includes: name, date of birth, social security number, insurance information, medical information including, but not limited to, medication lists and diagnostic results, and personal information such as address, phone number and employer information. With your permission we may request records from healthcare professionals that you have seen in the past. We will not disclose this information to outside parties except as authorized by yourself in our Authorization to Use and Disclose Protected Health Information (PHI) form.

You have the right to view any medical information of yours that we hold. In order to receive a copy of your information, you would need to submit a request in writing.

Through your authorization, personnel in our office may view your personal information as required. This includes our medical staff, billing staff, receptionists/schedulers, clinical research staff, and ancillary staff.

As the offices function as a research site, in addition to a medical clinic, our clinical research staff may occasionally view your information in order to determine if you may be eligible for a study. Potentially, you might be contacted regarding a research opportunity.

If you have any questions regarding your privacy rights, please ask any of our staff or contact:

Privacy Officer: Amber Emanuel
3860 Crater Lake Avenue Medford, OR 97504
541.858.1003

I would like a copy of this ***Summary Notice of Privacy Practices*** after I have signed it: Yes_____ No _____

** I would like a copy of your ***Complete Notice of Privacy Practices***: Yes _____ No _____

____ ____________________

Printed Name of Patient Date of Birth

____ ____________________

Signature of Patient (or Guardian) Date