NEUROLOGY AND SLEEP SCIENCES
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT and PATIENT COMMUNICATION AUTHORIZATION

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name_____
Date of Birth_____SSN_____
Email Address _____

Please check to tell us how you wish to be contacted.
Please note: first box is to check preferred method of communication.

- ☐ Home: _____ ☐ *Okay to leave a detailed message* ☐ *Name/# only*
- ☐ Work*:* _____ ☐ *Okay to leave a detailed message* ☐ *Name/# only*
- ☐ Cell*:* _____ ☐ *Okay to leave a detailed message* ☐ *Name/# only*
- ☐ Patient Portal*:* _____ ☐ *Okay to send a detailed message* ☐ *Name/# only*

Written Communication
☐ Okay to mail to my home ☐ Okay to mail to my office/work

Mailing Address_____

Please tell us with whom we are allowed to speak with. We cannot speak to ANY family member without authorization except in emergency situations. This does NOT include the release of any documentation of visits or testing. An authorization is still needed to release records.

Name	Relationship To Patient	Phone	What NSS can discuss
_____	_____	_____	☐ All info ☐ Limit to_____
_____	_____	_____	☐ All info ☐ Limit to_____
_____	_____	_____	☐ All info ☐ Limit to_____
_____	_____	_____	☐ All info ☐ Limit to_____

- ❑ If at any time I wish to change the information provided on this form, it is my responsibility to ask for a new form so my chart can be updated.
- ❑ My signature below indicates that I have been offered a written copy of the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.
- ❑ My signature below indicates that I received a copy of Neurology and Sleep Sciences Welcome Letter regarding office policies.

Patient Signature/Legal Representative_____Date_____

PLEASE NOTE: We must have a copy of any Power of Attorney/Guardianship papers for your chart before your appointment or any communication is made by phone. Group homes please provide a medical treatment release.