Integrated Sleep Services

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HIPAA CONSENT FORM

Please tell us with whom we are allowed to discuss and/or disclose your personal health information.

Please circle all that apply:

Myself Only **Spouse** **Parents** **Sibling(s)**

Adult Children **Personal Representative** **Employer**

Please print name(s) of above:

_____

_____

My signature below authorizes the release of medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

_____
Patient / Responsible Party Name

_____ _____
Patient / Responsible Party Signature Date

_____ _____
INS/ISS Employee Signature Date