Pulmonary & Sleep Associates of Huntsville

DISCLOSURES & PRIVACY PRACTICES

Patient Name: _____ **DOB:** _____

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 communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

	Phone Number	OK to leave message with detailed information	Leave message with call-back number only
Home Phone		☐	☐
Work Phone		☐	☐
Cell Phone		☐	☐

I acknowledge that I have received a copy of the Notice of Privacy Practices and that Pulmonary and Sleep Associates of Huntsville may, at its discretion change the terms and conditions of this notice.

(Please Initial) _____

Release of Medication History Authorization:

I give Pulmonary and Sleep Associates of Huntsville permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed as part of my medical records release.

(Please Initial) _____

Pulmonary and Sleep Associates of Huntsville and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name	Relationship	Phone Number

Printed Name: _____

Signature: _____ Date: _____

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