GHALY
sleep center

HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). **Sleep Insights Medical Associates PLLC** Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

Sleep Insights Medical Associates PLLC needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below. We will witness your signature.

_____

Print Patient Name (and Guardian name if applicable) **Patient Date of Birth**

I give my consent for **Sleep Insights Medical Associates PLLC** to use and disclose my PHI to carry out TPO. With this consent **Sleep Insights Medical Associates PLLC** may mail items or call my home (or other alternate locations) to facilitate treatment, payment, and healthcare operations. They may leave messages concerning healthcare information (such as appointment reminders, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

___ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to Sleep Insights Medical Associates PLLC to also specifically speak with:

___ spouse: _____

___ relative: _____

___ DOT or employer-directed physician: _____

___ other: _____

Sleep Insights Medical Associates PLLC may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

_____

_____

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

_____

Signature of Patient **Date**