Florida Sleep Specialists

Diagnosis and Treatment of Sleep Disorders
American Academy of Sleep Medicine Accredited

HIPPA Disclosure Agreement & Disclosure information

Do we have permission to leave the following on your voicemail?

*Appointment Information YES ☐ NO ☐

*Medical Information YES ☐ NO ☐

*Billing Information YES ☐ NO ☐

*Contact you at work YES ☐ NO ☐

Other than my physicians, I authorize the following person(s) to receive information regarding my medical condition, appointments, and billing:

____

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I would like to receive information/sign up for the Patient online Healthcare Portal: ☐ YES ☐ NO

I understand that the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this (HIPPA) authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

I hereby acknowledge that I received Sleep Manatee's Notice of Privacy Practices.

Name of Patient (please print): ________________________________

Patient Signature: ____

Date: ________________________