The Snoring Center
SnoringCenter.com

PRIVACY COMMUNICATION FORM

In complying with the health information privacy act, HIPAA, we want to make sure that we guard your privacy according to your wishes when it comes to family, friends and co-workers.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

May we contact you via email for treatment follow-up?	**YES**	**NO**
May we leave messages on an answering machine at home?	**YES**	**NO**
May we leave messages on a voicemail at work?	**YES**	**NO**
May we discuss your appointments/treatments with your spouse?	**YES**	**NO**
May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	**YES**	**NO**
Are there persons other than yourself (i.e. spouse, children or other family members, etc.) that you would wish us to discuss your appointments/treatments with if requested? If so, please list name and relationship below.	**YES**	**NO**

NAME ***RELATIONSHIP***

1.____

2.____

3.____

4.____

You must inform us, in writing, of any charges in your directives. This record takes effect on the date below and will be kept in your file along with your acknowledgements of receipt of our Notice of Privacy Practices.

Signature: ______________________________ **Date:** _____ / _____ / _____

Witness Signature: ______________________________ **Date:** _____ / _____ / _____

RELEASE OF INFORMATION

I authorize The Snoring Center to release any medical information requested by representatives of local, state or federal agencies, insurance companies or other organizations or entities as may be required by said representatives for pay of claims arising out of these medical services as are due The Snoring Center.

Signature: ______________________________