



Hackensack Sleep & Pulmonary Center

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HIPAA PRIVACY ACT PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient

Patient Date of Birth

Signature of Patient or Guardian

Date

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This HIPAA consent is valid up to one year. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures:

1. Individual Name

Relation to Patient

2. Individual Name

Relation to Patient

**Signature of Patient or
Legally Authorized Representative**

Date

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.