



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 leave messages concerning your appointments/treatment with a co-worker, receptionist, or secretary that regularly answers your calls? YES NO

May we leave messages on a voice mail at work? YES NO

May we leave messages on an answering machine at home? YES NO

May we discuss your appointments/treatment with your spouse? 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 appointment/treatment 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 changes in your directives. This record takes effect October 25, 2003 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature: _____ Date: _____

Witness: _____

RELEASE OF INFORMATION

I authorize Snoring Center of Dallas 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 _____