

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I have received Wake Sleep's Notice of Privacy Practices. I understand that Wake Sleep may use and disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations when I notify the practice accordingly. I also understand that Wake Sleep will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use of disclosure of my personal health information for purposes as noted in Wake Sleep Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

(Patient Name) (Patient Signature) (Date)

If the patient is a minor, please have parent or legal guardian sign and date below.

(Parent/Legal Guardian Name) (Parent/Legal Guardian Signature) (Date)

I authorize Wake Sleep staff to leave messages regarding my personal health information and/or appointment reminders at:

My home telephone number My work telephone number My cell phone number
Yes ___ No ___ Yes ___ No ___ Yes ___ No ___

I authorize Wake Sleep's Staff to discuss my personal health information with the following people:

I authorize Wake Sleep and Staff to send my sleep study report to Durable Medical Equipment companies for the purpose of CPAP and BIPAP set ups and supplies when and if this is necessary.

Yes ___ No ___