The Institute for Respiratory and Sleep Medicine

Acknowledgement of receipt of Notice of Health Information Practices

Patient name: _____ Date of birth: ____/____/_____

By signing below, I acknowledge that I have received a copy of the Notice of Health Information Practices of The Institute for Respiratory and Sleep Medicine.

_____ ____/____/_____
Signature of patient or personal representative Today's date

_____
Description of personal representative's authority

Authorization to disclose protected health information

By signing my signature below, I hereby authorize the disclosure of my protected health information to the person(s) listed below:

Name: _____ Date of birth: ____/____/_____ Relationship: _____

Name: _____ Date of birth: ____/____/_____ Relationship: _____

Name: _____ Date of birth: ____/____/_____ Relationship: _____

Name: _____ Date of birth: ____/____/_____ Relationship: _____

Patient signature: _____ Date: ____/____/_____

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS OTHERWISE NOTED

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