Sleep Better
OREGON

HIPAA Privacy Authorization Form

Patient Information: Name: _____Date of Birth: _____
Address: _____City: _____
State: _____ ZIP: _____ Phone: _____Email: _____

Authorization
I acknowledge that I have the right to authorize access and disclosure of my protected health information (PHI) to anyone of my choosing. This includes all billing, treatment and prognosis to the following individuals.
Name:_____Relationship_____Phone_____
Name:_____Relationship_____Phone_____
Name:_____Relationship_____Phone_____

Information to be Disclosed
Specific information to be disclosed includes (check all that apply):

- □ Complete Medical Record
- □ Billing Information
- □ Appointment Information
- □ Treatment Plans
- □ Diagnostic Test Results
- □ Other (please specify): _____

Patient Rights: I understand that, please check all

- □ I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization.
- □ I may refuse to sign this authorization, and such refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- □ Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

Signature and Date
Patient Signature: _____Date: _____
If signed by a personal representative, please complete the following:
Name of Personal Representative: _____
Relationship to Patient:
_____
Signature of Personal Representative: _____Date:
_____

Acknowledgment of Receipt of Notice of Privacy Practices
I acknowledge that I have received a copy of Sleep Better Oregon's Notice of Privacy Practices.
Patient Signature: _____
Date: _____

Sleep Better Oregon
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