TALLAHASSEE SLEEP DIAGNOSTIC CENTER

LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

NAME: _____ DOB: _____

ADDRESS: _____

_____, _____, _____
CITY STATE ZIP

****

Which of the following communication means are appropriate/acceptable for TSDC to communicate with you. **(PLEASE CHECK ALL THAT APPLY):**

Home Phone # _____ Leave message to return call **(no particulars)**

Home Phone # _____ Leave message **with particulars**

Work Phone # _____ Leave message to return call **(no particulars)**

Work Phone # _____ Leave message **with particulars**

Cell Phone # _____ Leave message to return call **(no particulars)**

Cell Phone # _____ Leave message **with particulars**

Other # _____

WHO ARE YOU AUTHORIZING TSDC TO DISCUSS YOUR HEALTH SITUATION WITH: **(PLEASE CHECK ALL THAT APPLY):**

No One

Spouse _____ Ph #_____

Child _____ Ph #_____

Sibling _____ Ph #_____

Other _____ Ph #_____

Other/relation _____ Ph #_____

Other/relation _____ Ph #_____

I HAVE READ AND RECEIVED A COPY OF TSDC'S NOTICE OF PRIVACY PRACTICES.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**