Falcon Sleep Center
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Oviedo, FL 32765

Phone: 407-365-3033
Fax: 407-365-3034
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www.falconsleepcenter.org

Falcon Sleep Center Metrowest
6000 Metrowest Blvd.
Suite 104
Orlando, FL 32835

HIPAA ACKNOWLEDGEMENT AND DISCLOSURE FORM

I, _____, understand that as part of my healthcare, Falcon Sleep Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse. I understand that this information serves as:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

I understand that Falcon Sleep Center has developed a ***Notice of Privacy Policies*** that provides a more complete description of the permitted uses and disclosures of my health information and my rights with respect to my health information. I acknowledge that I have been provided a copy of the Notice of Privacy Policies and I understand that I have the following rights and privileges:

- The right to receive a paper copy of the Notice of Privacy Policies upon request,
- The right to object to the use of my health information for directory purposes,
- The right to request that communications of my health information be made by alternative means or at alternative locations, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and health care operations.

I understand that Falcon Sleep Center is not required to agree to the restrictions requested and that Falcon Sleep Center generally does not allow restrictions on the use and disclosure of health information. I further understand that Falcon Sleep Center reserves the right to change or eliminate provisions in its Notice of Privacy Policies from time to time and that Falcon Sleep Center will post any revised Notice of Privacy Policies in its office, and make it available to me upon request (via mail or electronic mail) in accordance with Section 164.520 of the Code of Federal Regulations.

Patient Name_____ Date of Birth_____

You are hereby authorized to furnish all my protected health information to:

Name_____ Date _____

Name_____ Date _____

Name_____ Date _____

Falcon Sleep Center can authorize to furnish protected health information (including appointments) via:
PLEASE SELECT THE METHOD OF CONTACTING

- ☐ Phone
  - ☐ Leave message on voicemail
  - ☐ Do not leave message on voicemail
- ☐ Mail
- ☐ Other: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my information, I can contact the number above.

I understand that I may revoke (at any time) this authorization. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Falcon Sleep Center at the address listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will not expire.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Falcon Sleep Center to use or disclose my health information in the manner described above.

Falcon Sleep Center will accept written revocations of this authorization via Certified US Mail or in-person. ALL revocations must be sent to Falcon Sleep Center to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

Patient/Legal Guardian/Power of Attorney's Signature _____ Date _____

If other than patient signing please advise the relationship to patient_____

Witness's Signature _____ Date _____