Houston
SLEEP AND NARCOLEPSY

www.sleepandnarcolepsy.com
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Patient Privacy

PATIENT NAME	DATE OF BIRTH (MTH/DAY/YEAR)	PARENT OR LEGAL GUARDIAN NAME

This Patient Privacy form will remain in your file and considered current. If there are any changes, you must complete and submit an updated form.

1. Please list other persons, if any, whom we may inform about the patient's general medical condition and diagnosis (including treatment, payment, and health care operations):

NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:
NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:

2. Please list any persons that can consent to treatment and medical care for the patient when legal guardian is not available to give consent:

NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:
NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:

3. Please list any persons that are authorized to pick up paperwork or prescriptions for the patient:

NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:
NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:

4. Please list other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:
NAME	RELATIONSHIP TO PATIENT	CONTACT TELEPHONE / EMAIL ADDRESS:

The patient may be contacted by our office with appointment reminders, healthcare treatment options or other health services. We will limit the amount of information left in messages to just the information necessary to confirm the appointment or to request a return call. We may contact you by mail, phone, text or email, using any information that you provided. You may request that Houston Sleep and Narcolepsy communicate with you in a certain manner. You must be specific and provide this request this in writing.

SIGNATURE OF PATIENT / PARENT OR LEGAL GUARDIAN	DATE