Ohio Sleep Treatment LLC

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Ohio Sleep Treatment to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Ohio Sleep Treatment to leave DETAILED messages for me when I am unavailable. I also understand that I have the right not to sign this agreement.

I authorize Ohio Sleep Treatment to leave detailed messages via these contact methods

Home Phone ☐ **Cell Phone** ☐ **Work Phone** ☐

Home Mail ☐ **Email** ☐ **Text Message** ☐

I authorize Ohio Sleep Treatment and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.
I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	**Relationship**	**Contact Information**

EMERGENCY CONTACT ONLY -

NAME: _____ Phone: _____

In general, the HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI) the individual is also provided the right to request confidential communication.

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that Ohio Sleep Treatment may impose.

_____

Patient/Guardian Signature Printed Date