Phone/Text: 844-387-5337

SleepHealthMD.com

Patient Name: _____ *DOB:* _____ *ID:* _____

Sleep Health MD values your privacy. We also understand that there are circumstances wherein you, our patient, will want or need a person or entity other than yourself to communicate with our office on your behalf. By entering the name of a designee below (spouse, friend, family member, legal representative, etc), we can aid you in that regard.

Unless and until you have listed a designated person/entity below, we will not be able to allow anyone other than you, the patient, access to any of the three areas listed below. Please update the fields below including the name(s), their relationship to you, and contact information of those you allow access to.

Name of Person/Entity	**SCHEDULING**	**BILLING**	**MEDICAL DECISION MAKING/ RECORDS**
Full name:			
Relationship:	**YES** ○ **NO** ◉	**YES** ○ **NO** ◉	**YES** ○ **NO** ◉
Mobile: Home:			
Full name:			
Relationship:	**YES** ○ **NO** ◉	**YES** ○ **NO** ◉	**YES** ○ **NO** ◉
Mobile: Home:			

I, _____, (printed patient name) authorize access by my signature below that the above listed person(s) has my permission to access the indicated areas of my health care.

Signature _____ Date_____