RCSA
RESPIRATORY
CRITICAL CARE &
SLEEP
ASSOCIATES
a division of unity health network

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please list below the names and contact information of individuals you authorize to receive your Personal Health Information (PHI).

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

For security purposes, please fill in one of the personal identifiers below so that we may verify whom we are speaking with before sharing your Personal Health Information (PHI).

Mother's Maiden Name: _____
Your City of Birth: _____
Your Favorite Color:_____
Create your own identifier: _____

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had.

May we leave this information on your voicemail? Yes No

May we leave appointment reminders on your voicemail? Yes No

If yes, please list your preferred contact number. Preferred Phone#: _____

Please list below the name(s) of the individual(s) that you would like us to contact in case of an emergency.

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

Name: _____
Relationship: _____
Home Phone#: _____
Cell Phone#: _____

I, _____, do hereby acknowledge receipt of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____