Sound a Sleep
SLEEP DIAGNOSTIC LAB
an Affiliate of Narendra R. Kumar, M.D., P.C

PERSONAL HEALTH INFORMATION (PHI) DISCLOSURE FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Please list below any/all individuals (husband, wife, family, friends, guardian, doctors, ect.) that we may discuss your (PHI) Personal Health Information with, including but not limited to; treatment, diagnosis, appointment dates & times, billing, payments, ect.

If you do not wish us to discuss your PHI with anyone please write **NONE** on any line below.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please initial if this authorization is permanent. _____ **OR**

This authorization expires on _____, 20____.

Patient Signature: _____

Print Save