THE LUNG CENTER

Sleep Disorders Specialists of Manatee

Michael D. Seeman, M.D. • Floyd W. Wells, M.D. • Michael W. Burke, M.D.

Pulmonary, Critical Care and Sleep Disorders Medicine

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ _____

Name of Patient (please print) Date of Birth

I hereby acknowledge that I received The Lung Center's Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

AUTHORIZATIONS

YES _____
NO _____ I hereby authorize you to leave medical information (appointment dates, times, prescription information) on my answering machine at home or my cell phone.

YES _____
NO _____ I hereby authorize you to call me at work.

Other than my physicians, I authorize the following person(s) to receive information regarding my medical condition:

PLEASE PRINT

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient Signature Date 6/6/03

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