NEUROLOGY & SLEEP ASSOCIATES OF SUFFOLK

Rajiv B. Nanavaty, M.D. | Shubh Sharma, M.D. | Lacey D. Lyle, FNP

DISCLOSURES TO FAMILY MEMBERS & FRIENDS

PATIENT'S NAME _____

Date of Birth _____ OR Last Four of Social _____

This Notice is effective as of January 1, 2016 and applies to Neurology & Sleep Associates of Suffolk, PLLC.

I hereby agree that disclosures may be made to family and friends (listed below as "Included") related to my health or as needed for payment of healthcare services. I also request my information not be shared with persons listed below as "Excluded". I also understand that in cases where this form is not accessible or in cases of emergency, the Physicians and Staff may use their best judgment in complying with my designation of healthcare and account information.

(Circle One)	**Relationship**	**Name**
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, state Relationship to Patient _____

150 Burnett's Way | Suite 320 | Suffolk, VA 23434 | Phone 757-934-1900 | Fax 757-925-6719

5839 Harborview Blvd. | Suite 201 | Suffolk, VA 23435 | Phone 757-967-0676 | Fax 757-967-0675