NeuroCare
CENTER FOR SLEEP

PLEASE FAX COMPLETED FORM TO: 617.796.9099
OR EMAIL TO: md@neurocareinc.com

Authorization by Professional Medical Practice Entity for staff access to practice PHI

Medical practice entity name_____, (the "Practice") dated: _____

I understand that the Neurocare Sleep Management Platform allows access to the referring physician portal with respect to patients who are referred for sleep testing only, and a unique user ID and password will be required. If another staff member in the practice wishes to share access to the patients' protected health information (PHI) for purposes of the treatment, payment and healthcare operations of the Practice, the approved staff will have access to all of the patients in the Practice. The Practice desires to request such shared access to authorized staff members of the Practice. The Practice shall instruct staff on required practice HIPAA policies and procedures, and will notify Neurocare when a staff member no longer has a need to know and to access the physician portal (system automatically discontinues access after lack of use as an additional precaution).

I,_____ (printed name), an authorized representative of the Practice, hereby authorize Neurocare to provide such shared access to the physicians and staff appointed by the Practice to access the Neurocare Sleep Management Platform physician portal, and to instruct authorized staff as required above.

_____

SIGNATURE

Shared access is approved for the following staff members:

Name	**Role**	**Email**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____