CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION
CONSENT FOR TREATMENT

Patient's Name:_____ SDC # _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____ have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative Date

Printed Name of Patient's Representative Relationship to Patient

For Treatment, payment or health care operations may we contact you by:
Please circle all that apply and then list phone numbers and addresses that apply.

Phone:_____ **Mail:**_____ **E-mail:**_____
_____ _____ **Fax:** _____
_____

If you have an answering machine/answering service – may we leave a message? ☐ YES ☐ NO
Please initial here_____

Our **Privacy Officer** can be contacted as follows: **Robert Drager, 3450 W. Central Ave. #118, Toledo OH 43606**
Phone: (800) 535-1724 Fax: (419) 535-9443 E-Mail: rdrager@sleepnetwork.com

I,_____, hereby authorize the physicians, their assistants, and personnel of The Regional Center for Sleep Medicine to administer to the patient a routine examination and/or medical treatment, procedure and/or diagnostic procedures specified by the physician. I also acknowledge that during the course of these procedures any unforeseen conditions that may be revealed might necessitate extensions of these procedures and/or different procedures might need to be added to the treatment.

_____ _____
DATE SIGNATURE OF PATIENT OR GUARDIAN

_____
WITNESS

(HIPAA4-K)

(IF PATIENT IS A MINOR PLEASE HAVE THE GUARDIAN FILL OUT THE ABOVE SECTION)