



Patient Authorization Form and Consent for Treatment

By signing below; I hereby authorize my health information, as more specifically described only for the purposes and parties also described below:

Sleep related treatment

- ∞ Lab evaluations
- ∞ Medications presently or previously prescribed
- ∞ Office evaluations

The specific person, or class or persons, who are authorized to use, or disclose, my Protected Health Information are Sleep Diagnostics of Michigan employees.

The person, or class of persons, to whom this office may disclose my Protected Health Information are (please check the box and insert name):

- Referring Physician Name: _____ Address/Ph# _____
- Spouse Name _____
- Guardian Name _____
- Specialist Name _____ Address/Ph# _____
- Other Name _____ Address/Ph# _____

This authorization shall remain in effect from the date signed below until you leave this practice.

I understand that:

- ∞ I may inspect or copy the protected health information to be used or disclosed
- ∞ I may revoke this authorization in writing by delivering written notice to: Sleep Diagnostics of Michigan, 611 Court Street, P.O. Box 428, West Branch, MI 48661.
- ∞ Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer by HIPAA.
- ∞ I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment in which case you may refuse to provide that research-related treatment).

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- ∞ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that that treatment directly and indirectly.
- ∞ Obtain payment from third-party payers.
- ∞ Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____
(if signed by personal representative of Patient)

Date: _____