Sleep Innovations, PLLC
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CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I hereby give my consent to Sleep Innovations, PLLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I acknowledge that I am aware of Sleep Innovations, PLLC Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed and states my right with respect to my medical information, effective April 14, 2003. I understand that Sleep Innovations, PLLC has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the Notice is revised, the revised Notice will be available at Sleep Innovations, PLLC and that I may obtain a current Notice of Privacy Practices at any time from the privacy officer at Sleep Innovations, PLLC. 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. 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.

Print Name_____

_____ _____

Signature of Patient / Guardian / Representative Date Signed

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If Guardian / Representative-State Relationship to Patient