The Sleep Disorders Center of Alabama
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by any physician of the Sleep Disorders Center of Alabama for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Sleep Disorders Center of Alabama. I understand that diagnosis or treatment of me by the physician I am scheduled to see may be conditioned upon my consent as evidenced by my signature on this document. I consent to the review of my protected health information by Research personnel who are employees of the Sleep Disorders Center of Alabama to determine my eligibility for participation in sleep-related Research studies and to be contacted regarding same.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Sleep Disorders Center of Alabama is not required to agree to the restrictions that I may request. However, if the Sleep Disorders Center of Alabama agrees to a restriction that I request, the restriction is binding on the Sleep Disorders Center of Alabama and any physician I may see in this practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the physician or the Sleep Disorders Center of Alabama has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Sleep Disorders Center of Alabama's Notice of Privacy Practices prior to signing this document. The Sleep Disorders Center of Alabama's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment *of my* bills or in the performance of health care operations of the Sleep Disorders Center of Alabama. The Notice of Privacy Practices for the Sleep Disorders Center of Alabama is also provided in the waiting room of this office. This Notice of Privacy Practices also describes my rights and the Sleep Disorders Center of Alabama's duties with respect to my protected health information.

My physician reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative : _____ Date: _____

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Name of Patient or Personal Representative: _____

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Description of Personal Representative's Authority: _____

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