COMPREHENSIVE SLEEP CENTER, PC

(D/B/A Comprehensive Sleep and Breathing Disorders Center)
1406 McFarland Blvd. North Suite #1C Tuscaloosa, AL 35406 P: (205)343-0004 F: (205)343-0092

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You are receiving healthcare services from Comprehensive Sleep Center, PC. You agree that all records concerning your care with Comprehensive Sleep Center, PC shall remain the property of Comprehensive Sleep Center, PC. You understand and agree that such information is used for:

1. Your Treatment: The provision and coordination of your healthcare which may require disclosure of all or any portion of you medical record information to you attending physician, consulting physician(s), and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient;
2. Payment For Your Services: Billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third-party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account;
3. Routine Healthcare Operations: Accreditation, certification, licensing or credentialing activities of Comprehensive Sleep Center, PC
4. Medical Research and Educational Purposes: You acknowledge that you have been provided with a complete description of the uses and disclosures of the patient's healthcare information and that the Notice has been reviewed prior to signing of this consent.

You understand that Comprehensive Sleep Center, PC reserves the right to change the Notice and that Comprehensive Sleep Center, PC will provide you with a revised Notice when you come to our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_______AGREE _______NOT AGREE

Restrictions Requested (if any):____

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below:

I (we), the undersigned patient and/or responsible party hereby authorize Comprehensive Sleep & Breathing Disorder Center, PC, its physicians, agents, employees or representatives to discuss or release any and all patient information about me, including, but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, ect. To the person or persons indicated below:

THIS AUTHORIZATION WILL EXPIRE AFTER ONE (1) YEAR.

______Spouse Name:______________________________Tele:____________________

______Parent(s) Name:______________________________Tele:____________________

______Child(ren) Name:______________________________Tele:____________________

______________________________________ ____________________

Patient Signature Date