

Consent to Use and Disclosure

All patients must sign consent to the use and disclosure of protected health information for the purpose of treatment, payment and conducting the day-to-day operations of Midwest Sleep Diagnostics.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use and disclosure of my protected health information by Midwest Sleep Diagnostics (hereafter referred to as "MSD") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of MSD. I understand that diagnosis or treatment of me by MSD may be conditioned upon my consent as evidenced by my signature on this document. 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. MSD is not required to agree to the restrictions that I may request. However, if MDS agrees to a restriction that I request, the restriction is binding on MSD.

I have the right to revoke this consent, in writing, at any time, except to the extent that MSD 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 MSD from another health care provider, health plan, or my employer. 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 MSD's Notice of Privacy Practices prior to signing this document. I understand that I may request a copy of this document at any time.

I understand that I am financially responsible for all fees unpaid by my insurance carrier.

I consent to my photograph/video being taken for medical documentation while I am at MSD.

I consent to and authorize MSD to perform a Polysomnography and CPAP Titration Study. These tests and procedures have been explained to me by my physician and/or assistants chosen by him. I understand that failure to participate in certain parts of these procedures may result in partial results or inconclusive data.

I request that payment of authorized insurance benefits be made to MSD for any services furnished to me by MSD.

Patient's Signature

MSD Representative Signature

Date: _____

Please list any individual(s) who you authorize us to discuss your medical condition: _____

