# SLEEP & BEHAVIOR MEDICINE INSTITUTE

Accredited Member of American Academy of Sleep Medicine

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## Patient consent for use and disclosure of information

I, _____ (printed name of patient or legal guardian if under 18 years of age) understand that by signing this agreement I give consent to allow Sleep and Behavior Medicine Institute (SBMI) to use and disclose my medical records for treatment, payment or health care operations, as permitted by and in compliance with point 164.506 in the HIPPA Law. I also understand that SBMI may share my information with their collection agency in case of non-payment or refusal of payment for the services received at this office. Any other requests for medical records or information about the patient need to be accompanied by a signed authorization to release that information. I understand that SBMI will not release any information about my condition to any family members without my prior approval. If under applicable law a parent, guardian, or other person acting in *loco parentis* has authority to act on behalf of an individual in making decisions related to health care, the office may disclose health information relevant to such representation.

In case of divorced parents, the guardian must give written consent to authorize the other parent to receive health care information regarding the minor.

I understand that I can revoke my consent at any time and that any revocation should include my name, my address, telephone number, date of the authorization and revocation, and my signature.

I understand that the terms of the authorization are governed by the Healthcare Insurance Portability and Accountability Act of 1996, and it's implementing regulations (HIPPA).

I hereby acknowledge understanding of this authorization.

_____

Print Name

_____ _____

Signature Date