Acknowledgement of Receipt of Notice of Privacy Policies from UNITED SLEEP MEDICINE

I, _______________________________, understand that as part of my health care, UNITED SLEEP MEDICINE originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge receipt of the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this acknowledgement,
- The right to access, inspect, and obtain copies of my Protected Health Information (PHI),
- The right to ask this provider to correct, amend, or delete my PHI,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations,
- The right to request an accounting of disclosures,
- The right to confidential communications with this provider at a different location.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (as described in the Privacy Policies Notice) and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that UNITED SLEEP MEDICINE is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this provider may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

I further understand that UNITED SLEEP MEDICINE reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should UNITED SLEEP MEDICINE change their policies, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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Print Name of Patient

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Patient's Signature (or signature of responsible party, if patient is a minor)

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Date

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FOR OFFICE USE ONLY:

Patient Account #: _____________________