AKNOWLEDGEMENT OF MEDICAL RECORDS
CONSENT FOR CONFIDENTIAL INFORMATION

I understand that my **health information** may include information created by the practice, (Emerald Sleep Disorders Center) may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this Center may **use, obtain and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with arrange and be reimbursed for quality, cost-effective health care. Including entry of data regarding testing and testing outcomes and medical information management and billing.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Patient Privacy** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

In order to provide your medical information to a family member/spokes person, you must designate an individual who is authorized by you to receive any health/medical information from the Emerald Sleep Disorders Center.

_____ Date: _____
Authorized Family Spokesperson's name

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Patient Privacy.

By: _____/_____/_____
Patient Signature Patient Name DOB

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____