

Sleep Disorders Institutes
11881 W. 112th St. Suite 101
Overland Park KS 66210
Phone (913) 754-3275 Fax (913) 754-3276
administrator@sleepdisordersinstitute.com

Patient Consent Form

Patient's Name: _____

You have the right to:

- Request a restriction on certain uses and disclosure of your information; however, we are not required to agree to a requested restriction.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record.
- Request that your health record be amended.
- Request communications of your health information by alternative means or at alternative locations.
- Receive an accounting of disclosure made of your health information.

Patient's Signature: _____ Date: _____