Sleep Disorders Institute Midwest
Phone (913) 754-3275 Fax (913) 754-3276
sleepdisorders@kc.rr.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:_________________