Southeast Regional Sleep Disorders Center
357 Woodruff Road
Greenville, SC 29607
(864) 627-5337

Patient Consent for Use and Disclosure of Protected Health Information

Date: _____ Patient Account Number: _____

I hereby give my consent for Southeast Regional Sleep Disorders Center (SRSDC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. SRSDC reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by the forwarding a written request to SRSDC, 357 Woodruff Road, Greenville SC 29615.

With this consent, SRSDC may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clincal care, including laboratory test results, among others.

With this consent, SRSDC may mail to my home or other alternative location any items that assist the facility in carrying out TPO, such as appointment reminders, prescriptions and patient statements.

With this consent, SRSDC may disclose my PHI to providers not affiliated with SRSDC to facilitate care provided to me.

By signing this form, I am consenting to allow SRSDC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent the facility has already made disclosures in reliance upon my prior request. If I do not sign this consent, or later revoke it, SRSDC may decline to provide treatment to me.

Signature of patient	Patient's social security number	Patient's date of birth
Print patients name	Signature of legal guardian, if applicable	Relationship to patient