CONSENT FORM

DATE (MM/DD/YY)_____ TIME_____A.M. / P.M.

I authorize _____ to be performed on
(TYPE OF PROCEDURE)

_____ under the direction of
(NAME OF PATIENT)

_____
(NAME OF PHYSICIAN)

The nature and purpose of the procedure, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the result that may be obtained.

I authorize administration of such medications as deemed necessary by the physician for the procedure. I consent to the taking of pictures with a camera before my nocturnal polysomnogram recording, and videotaping as a part of the diagnostic study. I hereby give permission to release any medical information in order to file any insurance claims. I also authorize the release of medical information from my physician to any consulting physicians in regards to this procedure. I also assign any benefits paid on my child or me to be paid directly to CMD Sleep Disorders Center. I understand that a separate bill for interpretation may be sent from the interpreting physician.

_____ _____
PATIENT (PARENT I GUARDIAN) WITNESS

_____ _____
DATE DATE