Wake Sleep Sleep Disorders Center

Accredited by the American Academy of Sleep Medicine
Wake Sleep is the Sleep Lab with a Sleep Clinic.
Diagnose, Treat and Educate

3100 Duraleigh Road Suite 302,
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Sleep Study Consent Form

I authorize a Nocturnal Polysomnogram, CPAP titration study, MSLT or MWT to be performed under the medical direction of Medical Director of Wake/*Sleep* Sleep Disorders Center.

The nature and purpose of this procedure, as well as the risks involved, and possible complications have been explained to me. No individual with Wake/*Sleep* Sleep Disorders Center or any other physician's office has given me a guarantee or assurance as to the results that may be attained from this study.

I understand that my study may be video and/or audio recorded for documentation of certain problems, such as restless leg movements, "night terrors", combative sleep, or at the request of my referring physician and for the safety of the patient or technician in a given situation. This recording will be used for diagnostic purposes only and will be kept long enough for the medical director or referring physician to confirm a diagnosis.

I hereby give permission to release any medical information on myself that may be deemed necessary as a part of this procedure. I also understand and consent to the results of this procedure being released to other physicians or medical equipment companies, deemed necessary of my continued care.

I consent to the release of medical records in the process of billing any insurance claims. I understand that Wake/*Sleep* Sleep Disorders Center will manage the Wake Sleep Disorders Center.

_____ _____
(Signature of Patient or Guardian of Patient) Date

_____ _____
(Witness) Date