Iowa Sleep

4060 Westown Parkway
West Des Moines, IA 50266

400 SE Delaware
Ankeny, IA 50021

This notice describes how information about you as a patient may be used and disclosed and how you can gain access to this information.

NOTICE OF INFORMATION PRACTICES

1) Under the Health Insurance and Portability and Accountability Act (HIPAA) of 1996, we are required by law to keep your medical information private and give you this notice of our practice in this regard. Your medical information may be used and disclosed for these purposes: Treatment, Payment, and Healthcare System Operations and Oversight. Examples of medical information disclosure include, but are not limited to, referrals to nursing homes, home health agencies, durable medical equipment companies, referral to other providers for treatment, insurance companies for claims including coordination of benefits with other insurers, and internal quality control and assurance including auditing of records.

2) Iowa Sleep is required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances (public health requirements and court orders).

3) Iowa Sleep will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. The authorization may be revoked by the patient at any time. Revocation must be written.

4) Iowa Sleep may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

5) Iowa Sleep will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

6) Iowa Sleep reserves the right to change the terms of its notice in accordance with HIPAA regulation amendments and to make new notice provisions effective for all protected health information that it maintains.

7) Iowa Sleep will provide each patient with a copy of any revisions of its Notice of Privacy Practices at the time of their next visit. Copies may also be obtained at any time at our offices.

8) Any patient may file a complaint to the Iowa Sleep and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Iowa Sleep, please address written correspondence to the Privacy Officer at the following address: 4060 Westown Parkway, West Des Moines, IA 50266.

9) The effective date of this notice is April 14, 2003

Iowa Sleep

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, Iowa Sleep originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical/procedural information to my bill.
- A means by which a thirds party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that *Notice of Information Practices* is available at the Iowa Sleep that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and will provide a copy of revisions at the time of the next visit. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. If I request a restriction in the disclosure of my health information, the Iowa Sleep will not send out the indicated restricted information unless required by law. I understand that I may revoke this consent in writing, except to the extent that the Iowa Sleep has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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Signature of Patient or Legal Representative: _____

Date: _____