NORTHSIDE HOSPITAL, INC.

SLEEP CENTER PATIENT EMAIL CONSENT

Name of Patient: _____ Phone #:_____

Patient's Date of Birth: _____ Date:_____

By signing this form, I, _____, acknowledge and understand that communications via email over the internet may not be secure or protected transmissions and could be intercepted by others. I give my consent for Sleep Center providers and staff to send me emails that may include my health information at the following email address:

_____ Yes, please email me at this email address: _____

_____ I do not wish to receive emails from the Sleep Center and prefer to be contacted directly.

I understand that signing this form is entirely voluntary if I wish to authorize Sleep Center providers and staff to send me emails **that may include my health information**.

I understand that this Consent can be revoked by submitting a written request to the Sleep Center. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing.

_____ _____

Signature of Patient or Legal representative Print name

_____ _____

Date Relationship to patient:

_____ _____

Interpreter (if applicable) Reason patient unable to sign

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Sleep Center.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received:_____