



CONSENT FOR POLYSOMNOGRAPHY

I understand that I will be undergoing a sleep study. Electrodes and other sensors will be attached to my body. The tape used may cause discomfort during removal and the tape or cream used may cause redness at the site of attachment. Lotion or cream is available for the redness if requested. During the study, I will be free to roll over in bed, but will have to ask for assistance to get out of bed (head box has to be disconnected). I will be observed and videotaped on closed circuit TV throughout the study. There are no significant risks to me from the test. I understand the reason for the test and the procedure has been explained to me.

Signature (patient or guardian)

Date

PERMISSION TO PHOTOGRAPH AND/OR RECORD VIDEO AND/OR AUDIO

I, _____,
Patient/Guardian

hereby authorize the taking of photograph(s) and/or recording of video and/or audio(s)

of _____,
Name of Patient

by Guam Sleep Center, or their representative, with the understanding that such photograph(s), audio, and/or video recording(s), may be used **solely to assist in evaluating my sleep; for clinical purposes; educational purposes; or in the event of legal action.** Guam Sleep Center and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio and/or video recording(s).

Any recordings obtained during the course of the sleep study will remain confidential and will be considered a protected portion of my medical record.

Any use of the video for medical education will not identify me by name.

Check here if you do **NOT** authorize use for educational purposes

Signature (patient or guardian)

Relationship to Patient

Date

Witness

Date