* **HOME SLEEP HEALTH CONSENT & RELEASE FORM**

I acknowledge that I am receiving a home sleep test or consultation from Home Sleep Health, its business partners and associates. Home Sleep Health acknowledges that it will provide you an FDA-cleared home sleep apnea testing device that will be interpreted by a board-certified sleep physician and that any online consultations will be conducted by a board-certified sleep physician.

I give my full permission to the staff of Home Sleep Health, and any of their business partners or associates, to conduct my home sleep test or any activities associated therewith including but not limited to online sleep consultations or providing therapy equipment or supplies. I hereby expressly waive any and all claims, which I might, now or at any future date, assert against Home Sleep Health or its employees, agents, assignees, designees, business associates, business partners or successors in interest arising from the performance of this sleep test or consultation, as well as any claims arising from any ancillary activity necessary to effectuate the sleep test. I understand the seriousness and risks associated with sleep apnea, and I affirm that I do not hold Home Sleep Health, its employees, agents, assignees, designees, business associates, business partners or successors in interest responsible if I elect not to pursue treatment after a positive diagnosis.

* Name



* Signature

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* Date

Date

* Submit