

**Boice Sleep Disorders Laboratory  
Naval Medical Center  
620 John Paul Jones Circle  
Portsmouth, VA 23708-2197**

**This form is designed to address any concerns you may have about the video taping of your sleep study and to obtain permission from you to video tape your sleep.**

**Your physician has requested that we video tape your sleep. This is usually to document the presence (or absence) of unusual behaviors during the night so that the physician reviewing the study will be better able to diagnose your condition.**

**By signing below, you are giving the BOICE Sleep Laboratory permission to video tape your sleep. The video tape may be viewed by the professional staff of the Boice Sleep Laboratory and various personnel undergoing training or indoctrination at this facility. The tape may be used for research or for purposes of medical education subject to the following conditions:**

- 1. Your name or the name of your family will not be used to identify such pictures.**
- 2. There will be no personal information (name, social security number, etc) viewable on the video tape.**
- 3. Said pictures are used only for purposes of medical/dental research.**

**I, \_\_\_\_\_ have read the above information and had all my questions concerning the Boice Sleep Laboratory's policy on videotaping my sleep answered. By signing below, I hereby give permission to have my sleep videotaped.**

**Patient Name: \_\_\_\_\_ Date and Time: \_\_\_\_\_**

**Witness: \_\_\_\_\_ Date and Time: \_\_\_\_\_**