Authorization for Release of Medical Information

This form will be use to obtain medical records from another provider to Sleep Health MD

Patient's Name:_____

Date of Birth:_____

I hereby authorize Sleep Health MD to obtain my protected health information (PHI) as defined by Federal and State law. I understand that this authorization is voluntary.

The following information may be disclosed to Sleep Health MD:

- ☐ Medical Records
- ☐ Test Results
- ☐ Other

*_____

_____

_____

The following section must be competed in full in order to obtain medical records

This Health Information may be disclosed by:

Name of the Provider:_____

Address:_____

_____

Phone:_____ Fax:_____

I understand that my health care will not be affected if I do not sign this form. This authorization will expire on

_____ or 5 years from the date of my signature below, whichever is earlier.

I also understand that I may revoke this authorization at any time by notifying Sleep Health MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Sleep Health MD in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.