CALIFORNIA CENTER FOR
SLEEP DISORDERS
AASM Accredited Sleep Disorders Center

Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____

I hereby authorize_____, to use and disclose my protected health information ("Health Information") as defined by Federal and State law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

The following Health Information may be disclosed

☐ Medical Records
☐ Test Results
☐ Other _____

This Health Information may be disclosed to: _____

Mailing Address:

Telephone#

Relationship to Individual: ☐ Self ☐ Physician/Healthcare Provider ☐ Attorney
☐ Spouse/Relative ☐ Other _____

This Health Information may be used only for the following purpose:

_____
_____
_____

Authorization for Disclosure for Medical Research:

☐ I herby authorize CCSD to use my Health Information, and/or test results for anonymous medical research. I understand that CCSD will not disclose any personal information that would identify me with my Health Information to any individual or company outside of its employees and/or direct agents.

☐ I authorize CCSD to review my personal health information for medical research protocols that I may be interested in becoming a participant.

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

I understand that 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 CCSD in writing. I understand that my revocation of this authorization will not affect any actions taken by CCSD 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.

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