<u>Medical Records Release Instructions</u>

NOTE: Medical Records Release form <u>MUST</u> be filled out and signed!

Once the form is complete and signed, you may use the following options to return the form:

1. Send by **mail** to: 1665 Dominican Way, Suite 222, Santa Cruz, CA 95065 Attn: Medical Records Dept.

2. **Fax** to: (866) 264-3890

3. **Drop Off Locations:**

   *Santa Cruz:
   1665 Dominican Way #222, Santa Cruz, CA 95065
   *WATSONVILLE:
   150 Carnation Drive #4, Freedom, CA 95019
   *LOS GATOS:
   777 Knowles Drive #15, Los Gatos, CA 95032
   *SUNNYVALE
   260 S. Sunnyvale Avenue #6, Sunnyvale, CA 94086

If you have any questions or concerns please call (844) 387-5337 x 105.

Patient's Name: **Date of Birth:**

I hereby authorize Sleep Health MD, 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 by Sleep Health MD:

- ☐ Medical Records
- ☐ Test Results
- ☐ Other (APPROX DATE OF SERVICE / /)

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This Health Information may be disclosed to: ____

Mailing Address: ____

Telephone# ______________________________ Fax # _________________________________

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

This Health Information may be used only for the following purpose:
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Authorization for Disclosure for Medical Research:

☐ I hereby authorize Sleep Health MD to use my Health Information, and/or test results for anonymous medical research. I understand that Sleep Health MD 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 Sleep Health MD 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. 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.