Advanced Sleep Centers

HEALTH INFORMATION USE AND DISCLOSURE AUTHORIZATION

PATIENT INFORMATION

NAME: _____

DOB:_____/_____/_____SS#_____

ADDRESS: _____

CITY _____STATE_____ZIP_____

DAY/WORK TELEPHONE (_____) _____-_____

RELEASE INFORMATION – CHOOSE ONE BOX

☐ ☐I authorize Advanced Sleep Centers to RELEASE medical records information to:

☐ ☐I authorize Advanced Sleep Centers to OBTAIN medical records information from:

NAME: _____

ADDRESS: _____

CITY: _____STATE_____ZIP_____

PURPOSE FOR REQUEST

☐ Continued Care ☐ Attorney ☐ Personal Use ☐ Insurance Claim ☐ Other _____

I understand that I am entitled to ONE FREE COPY of my medical records during my lifetime. Any additional copies sent for any reason are subject to a copy fee of $1 per page.

This is the first requested copy of my medical records ☐ YES ☐ NO

INFORMATION NEEDED

☐ Entire Medical Records ☐ Progress Notes from date _____to _____

☐ Laboratory Results ☐ Test results ☐ Other _____

I understand that the information in my health record may include information related to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behaviors or mental health services and treatment for alcohol and/or drug abuse.

AUTHORIZATION

This authorization is effective for the duration of my treatment unless revoked or terminated by the patient's personal representative. It is understood that my records may not be released to me at the same time as requested. It can take anywhere from 24 hours to 30 days from the time of the request of my medical records.

You may revoke or terminate this authorization by contacting Advanced Sleep Centers. I understand that revocation will not apply to information that has already been released in response to this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information is in compliance with the Health Insurance Privacy and Portability Act of 1996 (HIPPA).

_____

Patient Signature/Authorized Representative Relationship to Patient Date

_____

Witness Signature Date