HEALTHY SLEEP MD

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Request for Access or Authorization for Use and Disclosure of Protected Health Information

Patient name _____ DOB: _____

Address _____ Phone: _____

I give permission to Healthy Sleep MD to use or disclose my protected health information as indicated below.

Healthy Sleep MD is requesting information from / to:

Facility Name _____

Address _____

_____

Phone _____

Fax _____

Email _____

Information to be released- check below:

☐ Entire Record
☐ Office Visit Notes
☐ Lab/ Imaging/ Procedure Results
☐ Other (please specify) _____
☐ Sleep Study Results
☐ Medical Record Only
☐ Financial Record Only

Acknowledgement of Understanding: I authorize the above medical information to be released as indicated above. I understand this authorization will remain in place unless I submit a written statement to Healthy Sleep MD requesting to revoke access. I understand that if I release my medial record to a person or provider, they can release my record. I understand I need to verify their privacy rules.

_____ _____
Printed Patient Name or Representative Today's Date

_____
Patient Signature or Representative