SLEEP MANAGEMENT INSTITUTE
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ _____, hereby authorize disclosure and release of my
(First,Last Name) (Date of Birth)
Protected Health Information in specifications listed below.

Authorization Given To:

_____
(Name of Physician or Facility)

_____
(Address)

_____
(City/State/Zip)

Release Records To:

_____
(Name of Physician or Facility)

_____
(Address)

_____
(City/State/Zip)

Information to be disclosed/released:

_____

_____

(Specifically describe the information to be released, including, but not limited to, descriptors, such as date and type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being released for the following purposes:

_____

_____

(List specific purposes above.)

This authorization shall be in force and effect until this request is processed, unless you specify that this authorization be effective for an additional period of time.
Date or Event: _____
(*Specify the date or event that relates to this disclosure at which time this authorization expires.*)

I authorize Sleep Management Institute to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS Virus (HIV).

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending such written notification to Sleep Management Institute's Privacy Officer.

I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Sleep Management Institute will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.

I understand that I have the right to:
- Inspect or copy the protected health information to be disclosed as permitted under federal law.
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____
Signature of Patient or Patient Representative Date

_____
Name of Patient or Patient Representative (Please Print)

_____
Description of Patient Representative's Authority