AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

____ **hereby authorize the use or disclosure of the individually**
Print Patient/Legal Representative or Patient/Legal Guardian Name

identifiable health information of ____ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information:	Person/organization authorized to **receive** the information:
Name/organization ___________________________________	Name/organization ___________________________________
Address ____	Address ____
City, state, Zip ______________________________________	City, state, Zip ______________________________________
Phone _____________________ Fax ____________________	Phone _____________________ Fax ____________________

For the purpose of: ☐ Legal ☐ Moving Out of Area ☐ Changing Physicians ☐ Continuing Care

☐ Other (please specify) ____

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits: however, the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not a health care provider, plan, or business associate (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and it no longer be protected by federal privacy regulation. Additionally, the authorized provider would not be held responsible for any re-disclosure by the person or organization that receives the information.

This authorization will expire on __________________ (NOTE: if left blank, it will expire 12 months from the date signed).

Date(s) of Service: From: ____ To: ______________________________________

Place your <u>INITIALS</u> by each item to be released or reviewed:

______Prescriptions ______ Billing Records

______ Sleep Studies ______Other (specify) ______________________________

______ Complete Record (charges may apply)

____ ____________________

Print Patient/Legal Representative or Patient/Legal Guardian Name ***Signature Required*** Date of Authorization

________________ ________________

Patient Date of Birth Telephone Number

____

Address City State Zip Code

Official Use Only: ____

Name of Person Releasing Information Date

Coping Costs:

The charge for copying costs for medical records is one dollar ($1.00) per page up to twenty-five (25) and twenty-five cents ($0.25) for each page thereafter. Please allow seven (7) to ten (10) business days for records to be copied.

Please mail, fax, or email your completed medical records request form to:

Sleep Technologies
8440 SE Sunnybrook Blvd. Suite 208 Clackamas, OR 97015

Fax: (503) 343-6554

Email: info@sleeptechnologies.com

To email your request, please complete this form in its entirety, scan as an attachment and email to info@sleeptechnologies.com

Thank you.