



Authorization for Release of Medical Information

This form will be used to obtain medical records from another provider to Sleep Health MD

Patient's Name: _____

Date of Birth: _____

I hereby authorize Sleep Health MD to obtain my protected health information (PHI) as defined by Federal and State law. I understand that this authorization is voluntary. The following information may be disclosed to Sleep Health MD:

- Medical Records
- Test Results
- Sleep Studies
- Other: _____

The following section must be completed in full in order to obtain medical records

This health information may be disclosed by:

Name of the Provider: _____

Address: _____

Phone: _____ Fax: _____

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.

Signature: _____ Date: _____

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.

Santa Cruz
1665 Dominican Way #222
Santa Cruz, CA 95065

Watsonville
150 Carnation Drive #4
Freedom, CA 95019

Monterey
101 Wilson Rd Suite D
Monterey, CA 93940

Sunnyvale
260 S. Sunnyvale Avenue #6
Sunnyvale, CA 94087