



Medical Record Release Form

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize Sleep Health MD, to use and disclose my protected health information ("Health Information") as defined by Federal and State law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

The following Health Information may be disclosed by Sleep Health MD:

- Medical Records
Test Result
Other: \_\_\_\_\_ (Approximate date of service \_\_\_ / \_\_\_ / \_\_\_)

\*Patient Signed Medical Records Disclosure\*

This Health Information may be disclosed to: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Relationship to Individual:

- Self, Spouse/Relative, Physician/Healthcare Provider, Attorney, Other: \_\_\_\_\_

This Health Information may be used only for the following purpose: \_\_\_\_\_

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.