

Patient Name:		Date of Birth:	
Name of Parent/Legal Guardian (if pt younger than 18):		Best Contact Number, including area code:	
Check One (✓) I am the : <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian with custody State relationship: _____		Release the following records - check (✓) : <input type="checkbox"/> Consultation note <input type="checkbox"/> PSG Report <input type="checkbox"/> Follow up notes <input type="checkbox"/> PAP Titration Report <input type="checkbox"/> All clinic notes <input type="checkbox"/> MSLT / MWT Report <input type="checkbox"/> All sleep study reports <input type="checkbox"/> All of the above <input type="checkbox"/> Other (specify): _____ Applicable Dates/Encounters (Specify): _____	

SEND RECORDS BY MAIL OR FAX TO:

PRINT name of Individual(s) or Agency		Fax #:
PRINT Street Address or Box Number:		
PRINT City:	PRINT State:	PRINT Zip Code:

- I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Fusion Sleep receiving a written notice of withdrawal.
- I hereby release Fusion Sleep and its officers, directors, agents and employees from any and all liabilities, responsibilities, damages, losses and claims which might arise from the release of the information authorized above.
- In furtherance of the authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

Purpose for which this release is being requested is:	
<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Legal Action/Review	<input type="checkbox"/> Undeclared (at the request of the below signed)
<input type="checkbox"/> Insurance Reimbursement	

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or in 6 months (12 months maximum), whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified.

Signature:	Date:
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