Authorization to Release Protected Health Information

RELEASE THE FOLLOWING RECORDS TO MY SPECIFIED PROVIDER: (Choose all that apply)

- Consultation Notes
- Follow-up Notes (Specify Clinic Date - Below)
- Sleep Study Results (Specify Test Date - Below)
- All Clinic Notes
- All Sleep Study Results
- All of the Above

SPECIFIC DATES OF SERVICE REQUESTED: (List all applicable dates to be included.)

____

Physician/Practice Name: ____

Phone: (___) ___-____

Fax: (___) ___-____

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 FusionSleep 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.

THE PURPOSE FOR WHICH THIS RELEASE IS BEING REQUESTED: (Choose one)

- Continuing Medical Care
- Legal Action
- Insurance Reimbursement
- IF "OTHER," PLEASE SPECIFY THE REASON: _____________________

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 special treatment dates prior to and on the date of signature, unless otherwise specified.

Patient Name:

____

I am the:

Patient

Parent/Legal Guardian

Signature:

____