Authorization to Release PHI to FusionSleep

I, _____ (patient name) authorize a representative from the following facility to disclose the above named individual's Protected Health Information (PHI) to FusionSleep.

Name of Individual(s) or Agency:
Street Address:
City, State and Zip Code
Fax: (___) ___-____
Phone: (___) ___-____

PLEASE RELEASE THE FOLLOWING RECORDS TO FUSIONSLEEP FOR CONTINUING MEDICAL CARE:

Choose all that apply:

- Consultation Notes
- Progress Notes
- Sleep Study Reports
- Laboratory Reports
- All Clinic notes

IF "OTHER," PLEASE SPECIFY: _____
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.

I am the:

Patient

Parent/Legal Guardian

Signature:
_____