AUTHORITY TO USE OR DISCLOSE HEALTH INFORMATION / MEDICAL RECORDS RELEASE

AUTHORIZE THE INSOMNIA AND SLEEP INSTITUTE OF ARIZONA TO RECEIVE INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Medical Record #: _____

Please release the following information:

❑ History and Physical with Most Recent Progress Notes for Visits and Labs

❑ Sleep Study Reports

❑ Entire Medical Record with Medication List

❑ Any Lab and/or Imaging Reports

❑ Other _____

The purpose of this request is for:

❑ Continuation of Medical Care

❑ Insurance/Release

❑ Other _____

I hereby authorize: _____

_____

_____

To disclose protected health information relative to my treatment and care to The Insomnia and Sleep Institute of Arizona.

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to The Insomnia and Sleep Institute of Arizona medical personal. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will automatically expire within 12 months from the date signed below.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Legal Representative Date

If Patient is unable to consent by reason of age or some other fact, state reasons:

_____

_____ _____ _____

Legally Authorized Representative Date Relationship to Patient

Please send results to: 8330 E Hartford Dr, Suite 100, Scottsdale, AZ, 85255-7205 or fax to: 480-745-3548