Whitney Sleep Center

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AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth _____
Patient Street/Box/Apartment # _____
Patient Address- City, State, Zip Code _____

I hereby authorize the following person or entity **to release** the information requested:
Name: _____
Street Address: _____
City: _____ State:_____ Zip Code: _____

I hereby authorize the following person or entity **to receive** the information requested:
Name: _____
Street Address: _____
City: _____ State:_____Zip Code: _____

I hereby authorize and Request that a Copy of the Following Individually Identifiable Health Information be released: (Please check appropriate boxes)
( ) All medical information from the following time period: __/___/___ through_____/___/____
( ) Office visits from the following time period: ____/____/_____ through _____/___/____
( ) Test results from the following test (s) (describe) _____
( ) All test results from the following time period ___/____/_____ through ___/ ____/____
( ) Operative Notes ( ) **Discharge Summary ( ) Other: Explain** _____ _____

This authorization will expire on: _____ (Date or Defined Event)
Note: Your authorization to release the above medical information may include the release of informationrelated to mental health, alcohol or drug dependency, HIV/AIDS or Sickle Cell Anemia. If you do NOT want this information released please check here ( )

The information is to be released for the following reason(s): Please check appropriate boxes:
( ) To review my current medical care ( ) Continuing Care (Referral) ( ) Insurance Change
( ) Attorney Office ( ) Leaving Practice ( ) Other: Explain _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except as Whitney Sleep Center has acted in reliance upon this authorization. *My written revocation must be submitted to Whitney Sleep Center's Privacy Officer at 2700 Campus Drive, Suite 100, Plymouth, MN 55441.*

Signature of Patient or Legal Representative _____ Date_____ ___
If Legal Representative Specify Relationship to Patient: _____

Print Name of Patient or Legal Guardian_____ _____