National Sleep Solutions Inc.
Sleep Specialist

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name:	Date of Birth:	Age:

___ I Hereby Authorize National Sleep Solutions to Release My Health Information to the Following:

Person/Agency:	
Address:	
Phone #:	Fax #:
Description of Specific Information	

Purpose of Releasing Information: □Treatment □Billing □Legal □School □Employment □Disability Determination □ Other: _____
Effective dates of authorization : ___/___/___ through ___/___/___ □ or until further notice is given.

___ I Hereby Authorize National Sleep Solutions to Obtain My Health Information from the Following:

Person/Agency:	
Address:	
Phone #:	Fax #:
Description of Specific Information	

Purpose of Obtaining Information: □Treatment □Billing □Legal □School □Employment □Disability Determination □ Other: _____
Effective dates of authorization : ___/___/___ through ___/___/___ □ or until further notice is given.
The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
□ Drug, Alcohol or Substance Abuse Records
□ Mental Health Records (except Psychotherapy Notes)
□ HIV / AIDS-Related Information (including Test Results)
□ Genetic Information (including Test Results)

I certify that I have read this form and agree to the uses and disclosures of information as described. I understand that I have the right to revoke this authorization at any time by submitting written notice to National Sleep Solutions. I also understand that National Sleep Solutions may not condition my treatment, payment, enrollment, or benefits eligibility on my authorization to use or disclose the above information. Furthermore, I acknowledge that any disclosure carries with it the potential for unauthorized re-disclosure by the recipient and that the information disclosed may not be protected by federal or state privacy laws.

Signature of Patient or Responsible Party _____*Date*_____

If Responsible Party, Relationship to Patient: _____