Advanced Sleep Neurodiagnostics, PC

24001 orchard Lake RD. St.#140 Farmington, MI 48336
Phone: **248-442-3700** *Fax*: **248-442-8860**
www.sleepneuro.com

Authorization to Obtain, Release or Review Protected Health Information

Patient Information

Please Fill out Completely

Today's Date _____

Patient Name _____ Home Phone_____

Patient Address _____ Birthdate _____ Sex_____

City _____ State_____ Zip _____ Social Security No. _____

I, _____hereby authorize **Advanced Sleep Neurodiagnostics, PC** to:
Patient/Legal representative

- ☐ **Allow review** (open and closed records)
- ☐ **Release Copies** of protected Health Information of _____
- ☐ **Obtain records** Patient

From:

_____
Name of individual, healthcare facility or agency

_____
Address City

_____
State Zip Code

Send records to:

_____
Name of individual, healthcare facility or agency

_____
Address City

_____
State Zip Code

Place your initials by each item to be **released or reviewed**:

____Complete Record
____Abstract Record
____All Diagnostic test results
____Therapy Records
____Consultation/Progress Note(s)
____Radiology only
____Pathology/Operative Report(s)
____Labs only
____Other (please specify)_____
_____
_____
_____

In addition, place your initials by each specific item: (if applicable)

____Mental Health ___HIV testing ___Genetic Counseling/Testing Information ___Drug and/or Alcohol ___AIDS Information

For the **purpose** of: (check all that apply)

____a. Continuation of Care
____b. Disability Determination
____c. Insurance Billing
____d. Legal Matter
____e. School
____f. Worker's Compensation
____g. Employment/Prospective Employment
____h. Family/Significant Other involvement in treatment
____i. Other (must specify)_____
_____

This authorization expires (insert date, condition, or event)_____, or it expires six (6) months after it is signed if no other expiration date is specified above.

I may revoke this consent in writing at any time except for circumstances in which information has been released prior to the revocation.

_____ _____

Signature of Patient/ Legal Representative or Parent/ Legal Guardian **Date** of Authorization

Notice of federal and state laws against further disclosure to the person or organization receiving information:

This information may have been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal regulations (42 CFR, Part 2) and State laws (Public Act 258, Chapter 7, Section 748) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or is otherwise permitted by such regulations. A general authorization for the release of medical or other information in NOT sufficient for this purpose.