



# Advanced Sleep Neurodiagnostics, PC

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## Authorization to Obtain, Release or Review Protected Health Information

### Patient Information

Please Fill out Completely

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Patient Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

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:

#### Send records to:

\_\_\_\_\_  
Name of individual, healthcare facility or agency

\_\_\_\_\_  
Name of individual, healthcare facility or agency

\_\_\_\_\_  
Address City

\_\_\_\_\_  
Address City

\_\_\_\_\_  
State Zip Code

\_\_\_\_\_  
State Zip Code

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

- |                                  |                                    |                                   |
|----------------------------------|------------------------------------|-----------------------------------|
| ____ Complete Record             | ____ Consultation/Progress Note(s) | ____ Other (please specify) _____ |
| ____ Abstract Record             | ____ Radiology only                | _____                             |
| ____ All Diagnostic test results | ____ Pathology/Operative Report(s) | _____                             |
| ____ Therapy Records             | ____ Labs only                     | _____                             |

**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     | ____ f. Worker's Compensation                             |
| ____ b. Disability Determination | ____ g. Employment/Prospective Employment                 |
| ____ c. Insurance Billing        | ____ h. Family/Significant Other involvement in treatment |
| ____ d. Legal Matter             | ____ i. Other (must specify) _____                        |
| ____ e. School                   | _____   |

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 is NOT sufficient for this purpose.

\*\*\*\*\*NOTICE\*\*\*\*\*

The information contained in this tele-fax is intended for the individual to whom or entity to which it is addressed. It may contain privileged, confidential, or trade secret information, which is protected by law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify sender by telephone and return the original message to the above address via the U.S. Postal Service.