

I, _____, hereby authorize disclosure and release of my Protected Health Information in specifications listed below.

Authorization Given To:

(Name of Physician or Facility)

(Address)

(City/State/Zip)

Release Records To:

Sleep Management Institute

4460 Red Bank Expressway, Suite 230

Cincinnati, OH 45227

Information to be disclosed/released:

Any sleep related information.

(Specifically describe the information to be released, including, but not limited to, descriptors, such as date and type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being released for the following purposes:

Treatment of possibly sleep disorder.

(List specific purposes above.)

This authorization shall be in force and effect until this request is processed, unless you specify that this authorization be effective for an additional period of time.

Date or Event: _____

(Specify the date or event that relates to this disclosure at which time this authorization expires.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Sleep Management Institute's Privacy Officer.

I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Sleep Management Institute will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be disclosed as permitted under federal law.
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

Signature of Patient or Patient Representative

Date

Name of Patient or Patient Representative (Please Print)

Description of Patient Representative's Authority