Authorization for Use and Disclosure of Protected Health Information

I, hereby authorize the Sleep Disorders Center of
(print your name)
Alabama to use and/or disclose the following protected health information to (your doctor(s) name(s) - if not completed, no information will be released to any doctor)

[Specifically describe the information to be used or disclosed i.e. all medical records, etc.]

This protected health information is being used and/or disclosed for the following purpose(s):
[Provide a description of the purpose of each use and disclosure i.e. coordination of medical care.]

The use or disclosure requested under this authorization will not result in direct or indirect remuneration to the Sleep Disorders Center of Alabama from a third party.

I understand that the Sleep Disorders Center of Alabama may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

This authorization shall be in force and effect until :
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to inspect or copy the information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), and to revoke this authorization, in writing, at any time by sending such written notification to Jill Luckey at 790 Montclair Road, Suite 200, Birmingham, AL 35213. I understand that a revocation is not effective to the extent that the Sleep Disorders Center of Alabama has relied on the use or disclosure of the protected health information. *I understand that my protected health information may include information concerning sexually transmitted diseases and I authorize the release of this information for the purposes stated above.*
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (print)

DOB :

SS# :

Date :

Relationship to patient (or other authority to serve)