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Authorization for Release/Request of Protected Health Information

Patient Name: _____ Date of Birth: _____
 Address: _____
 City/State/Zip Code: _____
 Patient's Phone #: _____
 Date of Request: _____ Date Needed: _____

I authorize Alabama Sleep Clinic to release information to:	I authorize Alabama Sleep Clinic to obtain information from:
_____	_____
Name of Provider or Facility	Name of Provider or Facility
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone #/Fax # (include area code)	Phone #/Fax # (include area code)

Type of Records Requested: _____

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form.
- This cancellation will not apply to information already released in response to this authorization, or when the authorization was obtained as a condition of obtaining life insurance coverage.
- This authorization will expire 60 days from the date of my signature.
- Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- The use or disclosure of the information identified above is voluntary, and I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient. _____

Witness Date