SOMNIQUE
SLEEP HEALTH

Health Information Release Authorization

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Choose one:

_____ I authorize Somnique Sleep Health to release medical records information to:
_____ I authorize Somnique Sleep Health to obtain medical records information from:

Clinic/Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

The purpose of this request is to:

_____ Continuity of care _____ Attorney _____ Personal use _____ Insurance
_____ Other *I understand that I am entitled to one free copy of my medical records.*
Any additional copies requested are subject to a fee of $1 per page.

Information Needed:

_____ Last Chart Note only _____ Chart notes from Date: _____ to Date: _____
_____ Sleep Study results _____ Last Compliance Report _____ Other

Authorization:

I understand that the information in my health record may contain information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also contain information about behaviors or mental health services and treatment for alcohol and or drug abuse. This authorization is effective for the duration of my treatment unless revoked or terminated by the patient's personal representative. It is understood that my records may not be released to me at the same time as requested. It can take 24 hours to 30 days from the time of my request. I understand that I may revoke or terminate this request by contracting Somnique Health. I understand that revocation will not apply to information that has previously been released in response to this authorization. Information that is disclosed in this authorization may be disclosed again to the organization or person which it is sent. The privacy of this information is in compliance with the Health Insurance Privacy and Portability Act of 1996.

_____ _____
SIGNATURE DATE

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