44 Hughes RD, STE 2500 Madison AL 35758 Phone: (256) 464-2920 Fax: (256) 542-3200

# Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: ________________________________ Patient DOB: ______________________

Address: ______________________________________________ City: ________________

State: __________________________ Zip: ________________

SSN: ________________________ Telephone: _____________________________________

**Information Requested From**

Name of Person/Company: _______________________________________________________

Phone Number: __________________________ Fax Number: __________________________

Address: ________________________________________ City: _______________

State: ______ Zip: ____________

**Send Information To**

Name of Person/Company: _______________________________________________________

Phone Number: __________________________ Fax Number: __________________________

Address: ________________________________________ City: _______________

State: ______ Zip: ____________

Please Select Information to be Disclosed:

☐ Sleep Study Reports ☐ Progress Notes ☐ Lab reports ☐ Medication List

☐ Billing/ Financial Information ☐ History and Physical

☐ Other: ________________________________________________________________

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before they received my written notice of revocation.

By signing this form, I authorize the entities listed above to disclose my confidential health information by releasing a copy of the requested medical records.

Signature: ____________________________________ Date: _______/______/_________

Legal Representative: _______________________________________________

Relationship to Patient: ______________________________________________