



Vital Sleep Care

44 Hughes RD, Ste 2500
Madison AL 35758



1010 Airport RD, Ste A
Huntsville AL 35802

Phone: (256) 464-2920 Fax: (256) 542-3200

Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Patient DOB: _____

Address: _____ City: _____

State: _____ Zip: _____

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 Billing/ Financial Information

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: _____