MID-WEST CENTER FOR SLEEP DISORDERS
www.mwcsd.com

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

I request and authorize Mid-West Center for Sleep Disorders to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FAX : _____ Patient Email:

☐ **Please check this box if you would like a copy of <u>your records mailed/emailed to the</u> patient's address listed above for personal use.**

This request and authorization applies to:

☐ All healthcare information. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

☐ Other: _____

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Midwest Center for Sleep Disorders. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.
- I understand the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____