WATERLOO HEIGHTS DENTAL CENTER

HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF INFORMATION

I UNDERSTAND:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand this consent/authorization may be revoked at any time except to the extent already acted upon.
- I have the right to revoke this authorization by sending a notice stopping this authorization to Sleep Healers at the address listed above. The Authorization will stop on the date my request is received.
- I understand if the organization I have authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that the person/organization receiving the information will be billed (subject to state law) a cost-based fee for costs associated with providing the requested information.

Last Name:_____ **First Name:** _____ **Middle Initial:** _____

Address:_____ **City:** _____ **State**:____ **Zip:**_____

Patient Signature:_____ **Date:** _____

Authorized Representative: _____ Date: _____

(If other than the Patient) Relationship to Patient: _____

I authorize the following information to be released from my record(s):
Date of Service: ALL Interpretive Report: ALL Other (specify): ALL SLEEP STUDY INTERPRETATIONS

Some medical records contain extremely confidential information. I consent to the release of the following information (if left blank, authorization is not assumed):

- Information relating to drug or alcohol abuse _____ (initials)***
- Information relating to mental health issues _____ (initials)***
- Information relating to HIV testing, infection status, or care or treatment of AIDS _____ (initials)***

Organization Providing the information: Sleep Healers
Person/Organization to receive the Information

Name:_____ Fax Number:_____

Address: _____

DESCRIPTION OF EACH PURPOSE FOR THE USE OR RELEASE OF THE INFORMATION:
(PROVIDE A DETAILED DESCRIPTION OF THE ACTIVITY FOR WHICH THE INFORMATION WILL BE USED)

_____

_____

_____

_____

This authorization for release of the above information to the above named persons/organizations will expire 90 days from the date of signature.