AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH CARE INFORMATION

To: SLEEP DIAGNOSTICS, INC.

You are hereby authorized to disclose and release any and all of my medical records pertaining to care I have received in your office.

Information is to go to: PRIMARY CARE PROVIDER: _____

REFERRING PHYSICIAN: _____

INTERPRETING PHYSICIAN: _____

OTHER PROVIDER: _____

This authorization is valid for a period of one year from date of signature, unless retracted in writing.

Name	**D.O.B.**	**Date**
_____	_____	_____

Signature: _____ Social Security Number: _____

I understand that the health care information released pursuant to this Authorization includes oral communications as well as information recorded in any medium including, but not limited to, information recorded on handwritten, typed, or computer-generated records; film; audiotapes; videotapes; and computer discs.

I understand that necessary health care information can be exchanged to the extent necessary to provide health care to the patient unless specific written instruction to the contrary has been received (50-16-529 NCA).

TO THE AGENCY RELEASING INFORMATION:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 C.F.R., Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.