3056 Healthy Way Suite 124
Vestavia Hills, AL 35243
Phone 205-783-5323 Fax 205-783-5324

MEDICAL RECORDS RELEASE

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Alabama Sleep Therapy
   Name

   3056 Healthy Way Suite 124
   Address

   Vestavia Hills, AL 35243
   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.
8.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____ _____ _____
Signature of Individual or Guardian (The person about whom the information relates) | **Date** | **Date of Birth**

_____ _____
Witness | **Date**

A copy of this completed, signed and dated form must be given to the Individual or other signator.