Houston
SLEEP AND NARCOLEPSY

www.sleepandnarcolepsy.com
Tel: 713-465-9282
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Medical Release
Authorization to Release Protected Health Information

A medical release protects patients' privacy – whether you want Houston Sleep and Narcolepsy to request your records from another healthcare provider or in order for Houston Sleep and Narcolepsy to release your records to another healthcare provider. There is no charge to electronically transfer your records to another healthcare provider, and standard processing rates may apply for other parties.

I hereby authorize the use or disclosure of information from the medical record of:

PATIENT NAME	DOB (MTH/DAY/YEAR)

Check only one (1) box:

☐ I authorize Houston Sleep and Narcolepsy to **RELEASE** my medical records to:
OR
☐ I authorize the above-named organization to **RECEIVE** records from:

BUSINESS ENTITY/HEALTHCARE PRACTICE		CONTACT	
STREET ADDRESS	CITY	STATE	ZIP CODE
OFFICE PHONE	FAX NUMBER	EMAIL ADDRESS	

INFORMATION TO BE RELEASED:

☐ Sleep Studies
☐ Clinicals/Office Notes
☐ Radiology Reports
☐ Diagnostics/Labs
☐ Other:____

- I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.
- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV; behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time in writing and will present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. This authorization expires 180 days from the date of my signature unless specified in writing here: ________________________
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- To the party receiving this information: This information has been disclosed to you for records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without written consent to the person to whom it pertains, or as otherwise permitted by such regulations.

PRINTED NAME OF PATIENT/PARENT/LEGAL GUARDIAN	SIGNATURE	DATE (MTH/DAY/YEAR)