SSC
Snow Sleep Center, P.C.
Accredited by the American Academy of Sleep Medicine since 1991

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
MEMBER CENTER

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Authorization to Release Medical Records

_____ _____ _____
Patient Name (Print) Social Security # Patient DOB

I authorize Snow Sleep Center, P.C. to release/disclose my health information to the following Physicians or Entities involved in my medical care:

_____

Permission to release my entire medical record if necessary. Please initial each item below to indicate your understanding.

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present with my written revocation will not apply to information that has already been released in response to this authorization. I understand 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 authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Sign:_____ Date:____/____/____

*Patient signature or Signature of Person completing this form if not the patient: Parent____ Legal Guardian____ Other____

This authorization will expire on _____> This authorization expires 12 months from the date it is signed.