Total Sleep Management, Inc.
9550 Bonita Beach Rd., Suite 108
Bonita Beach, FL 34135
phone (239) 444-1919
fax (239) 444-1921

TOTAL SLEEP MANAGEMENT

Authorization to Use or Disclose Health Information

Patient Name: _____ DOB: _____
Please print full name

1. I authorize the use or disclosure of the above named individual's health information by Total Sleep Management, Inc. as described below.

2. The type of information to be used or disclosed is as follows:

- Clinic or Progress Note
- History and Physical Report
- CareLine Note
- Bill for Service
- Operative/Procedure Report
- Other: _____

The above information can be released for the period of _____.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to the following individual(s) or organization(s):

_____
Name of Organization or Individual

_____
Address

_____ _____
Phone Number Fax Number

5. This information for which I am authorizing disclosure will be used for the following purpose:

- My personal use _____
- Other _____
- Sharing with other health care providers _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

7. This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.

9. I understand the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
Signature of patient or legal representative Date

If signed by a legal representative, relationship to patient: _____

_____ _____

Signature of witness Date