Sleep Wellness Clinics of America, PLLC
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AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION

I hereby authorize the disclosure of the health information of the individual named below:
Patient's Name: ________________________________ Date of Birth: _____________

This information is to be disclosed FROM the following individual or organization: Doctor/ Practice __________________________
Address: ____
Phone: __________________ Fax:____________________

This information is to be disclosed To: **Sleep Wellness Clinics of America**

The following information is authorized for use, disclosure and redisclosure:
x Office visit notes x Sleep Study reports, x MSLT (Multiple sleep latency testing reports) Other :Insurance information

Reason for use, disclosure and Redisclosure: x Continuing Care , x Transfer of Care

x Durable medical equipment needs , x Communicate with PCP/other consultants.

SENSITIVE INFORMATION: l understand that my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
______(*Initials*)

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re -disclosure and that the information that may not be protected by federal confidentiality rules. _______ (*Initials*)

Signature of Patient/Representative:_______________________________

Patient’s Name (printed): ___________________________ Date: _______