



Sleep Wellness Clinics of America, PLLC

Bijoy E. John, M.D., FCCP

1612 Westgate Circle, Suite 210

Brentwood, TN 37027

TEL (615) 685-4670 FAX (833) 563 -1716

www.sleepwellnessinfo.com

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:

Office visit notes Sleep Study reports, MSLT (Multiple sleep latency testing reports) Other :Insurance information

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

I also understand the above reports can be used to facilitate care with

Durable medical equipment companies , Communicate with PCP/other consultants.

SENSITIVE INFORMATION: I 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.

REDISCLASURE: 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.

Signature of Patient/Representative: _____

Patient's Name (printed): _____ Date: _____