

**STELLAR SLEEP DIAGNOSTICS  
Patient's Consent for Disclosure of  
Protected Health Information (PHI)**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Release To Name: \_\_\_\_\_

Address: \_\_\_\_\_

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*(Please initial all that apply)*

\_\_\_\_\_ I request and authorize Peninsula Sleep Diagnostics to release the information obtained during my sleep study.

\_\_\_\_\_ I further authorize Peninsula Sleep Diagnostics to release information that was forwarded to us by other sources (if applicable) for the furtherance of my treatment.

\_\_\_\_\_ I specifically do not want the following information released: \_\_\_\_\_

Purpose of disclosure:

Further Medical Treatment     Legal Proceedings     Insurance Claim     Other: \_\_\_\_\_

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I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing HIV results or AIDS information.

This consent for release of information is good for 90 days unless otherwise noted with a future date entered here \_\_\_\_\_. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information. I also understand that a charge may be imposed if record duplication is excessive.

I understand that I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment of that care will not be affected unless otherwise stated. If the requestor or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be redisclosed.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Authorized to Sign for Patient

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Driver's License Number or ID #

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Witness