STELLAR SLEEP DIAGNOSTICS
Patient's Consent for Disclosure of Protected Health Information (PHI)
P (907) 646-1009 F (907) 646-1013

Date: _________________

Patient Name: ________________________________ DOB: __________________

Release To Name: ____

Address: ____

(Please initial all that apply)

________ I request and authorize Stellar Sleep Diagnostics to release the information obtained during my sleep study.

________ I further authorize Stellar 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: ____________________________

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Purpose of disclosure:
☐ Further Medical Treatment ☐ Legal Proceedings ☐ Insurance Claim ☐ Other: ______________________

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