THE CENTER FOR SLEEP MEDICINE

Authorization For Release of Information

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I authorize The Center For Sleep Medicine 10640 165th Street, Orland Park, IL 60467
(Facility/Person Releasing Information)

to release _____
(State specific nature of information to be disclosed)

_____

to: _____
(Receiving Person or Facility) (Address) (Fax # must be included)

The purpose or need for this disclosure:

Continuing Medical Care
(Continuing medical care, legal proceedings, insurance purposes, etc.)

I UNDERSTAND that my records are protected under the *Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND that the specific types of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical or psychiatric illness.

I UNDERSTAND that I have the right to revoke this consent at any time by my submitting a written and dated notice for revocation to the facility releasing this information. If not revoked, this authorization is valid until _____; otherwise, it expires 90 days from the date signed below.

It has been explained to me that if I refuse to consent to release of information, the following are the consequences:

_____

Dated: _____ Signature: _____
(Patient/Client, Legal Guardian)

_____
(If signature not of Patient/Client, specify legal relationship to patient)

Dated: _____ Witness: _____

*Federal Privacy Act (U.S. Code, Chap. 5, Sec. 550) IL Rev. Statutes (Chap. 110 S-2001)

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not redisclose any of this information unless the party who consented to this disclosure specifically consents to such redisclosure.

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulators. A general authorization for the release of medical or other information is not sufficient for this purpose.

Please complete this form in its entirety with witness signature and fax to Medical Records Department at 708-966-5335. Thank you!