



2700 Campus Drive, Ste. 100  
Plymouth, MN 55441  
P (763)519-0634  
F (763)519-0636

2412 East 117<sup>th</sup> Street  
Burnsville, MN 55337  
P (952)431-5011  
F (952)431-5013

www.whitneysleepcenter.com

### AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient Street/Box/Apartment # \_\_\_\_\_  
Patient Address- City, State, Zip Code \_\_\_\_\_

I hereby authorize the following person or entity **to release** the information requested:

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I hereby authorize the following person or entity **to receive** the information requested:

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**I hereby authorize and Request that a Copy of the Following Individually Identifiable Health Information be released: (Please check appropriate boxes)**

- All medical information from the following time period: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_
- Office visits from the following time period: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_
- Test results from the following test (s) (describe) \_\_\_\_\_
- All test results from the following time period \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_
- Operative Notes  Discharge Summary  Other: Explain \_\_\_\_\_

**This authorization will expire on: \_\_\_\_\_ ( Date or Defined Event)**

**Note: Your authorization to release the above medical information may include the release of information related to mental health, alcohol or drug dependency, HIV/AIDS or Sickle Cell Anemia. If you do NOT want this information released please check here ( )**

The information is to be released for the following reason(s): Please check appropriate boxes:

- To review my current medical care  Continuing Care (Referral)  Insurance Change
- Attorney Office  Leaving Practice  Other: Explain \_\_\_\_\_

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except as Whitney Sleep Center has acted in reliance upon this authorization. *My written revocation must be submitted to Whitney Sleep Center's Privacy Officer at 2700 Campus Drive, Suite 100, Plymouth, MN 55441.*

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_  
If Legal Representative Specify Relationship to Patient: \_\_\_\_\_

Print Name of Patient or Legal Guardian \_\_\_\_\_