Authorization to Release Patient Health Information

This authorization is necessary for us to comply with state and federal laws pertaining to the request and or release of medical records regarding the patient identified below. Please provide all of the requested information. Failure to provide all requested information may prevent Mountain Sleep Diagnostics from acting on this authorization.

Patient Name: **Date of Birth:**

Person/Entity Authorized to Release:

Name:	Mountain Sleep Diagnostics
Phone/Fax:	(303) 396-5923 | (303) 957-5414

Request Medical Records Sent To:

Name:	
Address:	
Phone/Fax:	

Records Requested:

☐All Medical Records

☐Records for a certain date range: _____ to _____

☐Billing Records Only

☐Other (please specify): _____

Sensitive Data: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐I Authorize Release

☐I Do Not Authorize Release

☐This is not applicable to me

I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.

Date: _____ **Signature:** _____

Please note, this request will expire 365 days from signature date. A copy of your Drivers' License is required to execute the requests of this document.