

[Provide a copy of this form to the patient.]

I authorize [name of person or entity]

_____ ,
to use the following protected health information [Specifically and meaningfully describe the protected health information to be used or disclosed.]:

_____ ,
for the purpose of disclosure to [List the name and contact information of specific entity or person to receive information.]:

_____ .
This protected health information is being used or disclosed for the following purposes [List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.]:

_____ .
This authorization shall be in force and effect until [Specify the expiration date, or an event relating to the patient for purposes of terminating this authorization.]:

_____ ,
at which time this authorization to use or disclose my protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Classic SleepCare LLC. I understand that a revocation is only effective to the extent that Classic SleepCare LLC has not already relied on this authorization to use or disclose my protected health information.

Classic SleepCare LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization for the requested use or disclosure.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient (or Personal Representative)

Date

Print Name of Patient (or Personal Representative)

Description of Personal Representative's Authority