PatientSleepSupplies

Authorization for Use and Disclosure of Protected Health Information

[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.]:

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_____

, 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 Patient Sleep Supplies and/or Gold Coast Medical. I understand that a revocation is only effective to the extent that Patient Sleep Supplies and/or Gold Coast Medical has not already relied on this authorization to use or disclose my protected health information.

Patient Sleep Supplies, Inc. 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*