Authorization for Release of Medical Records

PLEASE PRINT CLEARLY

Patient Name _____ DOB _____

_____

Street Address City State Zip

Daytime Phone ( ) - Evening Phone ( ) -

Authorization:

I hereby authorize and request SleepSafe Drivers, Inc. to disclose all medical records associated with physician consult, diagnostic testing and treatment of any sleep disorder to any entity involved in my care. This information may be shared by SleepSafe Drivers Inc., the sleep physician, home care company, sleep center, employer and/or DOT medical examiner involved in the testing, treatment, follow up or provider of benefits.

In addition, I also request the following entities to receive my health care information:

(If patient requests other entities to receive any medical information, please fill in the following)

Release information to:_____Address:_____
Phone:_____FAX:_____

Release information to:_____Address:_____
Phone:_____FAX:_____

You may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter to SleepSafe Drivers, Inc. or by filling out a revocation form available from SleepSafe Drivers, Inc.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized representative signature Date/Time

_____

Relationship to patient (if not signed by patient)

11300 Strang Line Road • Lenexa, KS 66215
855.723.3378