SLEEP APNEA solutions

Stanford Feinberg, MD, PC

Stanford Feinberg, MD • Sleep Medicine & Neurology
Linda Brown, MD • Sleep Medicine
Daniel Boone, PA-C • Sleep Medicine & Neurology

(O) 610-378-5566
(F) 360-462-6481

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(*Check One*)
Release _____ Releasing information from us to be released to you or to another provider
Request _____ Requesting information from another provider for review by our providers

Date: _____

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ C# _____ Social Security #: _____

I authorize the offices of Stanford S. Feinberg, M.D. and/or Sleep Apnea Solutions to **release/request** (*circle one*) the following:

Type of Records to be released.

____ Office Notes ____Lab Results ____Billing Information ____Entire Record

Purpose of Request:: ____Continuing Care ____Legal ____Personal Use ____Insurance

____Other: _____

To/From (*circle one*): _____

Address: _____

Phone: _____ Fax: _____

(It is important that you give as much contact information as you can; especially the provider's name and phone number)

- I understand that is authorization will be valid for ninety days effective, _____ *(date)*, but that I may revoke it in writing at any time, any such revocation shall have no effect on disclosures made previously.
- I understand I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may **not** be re-released to any other person or organization without my written consent.

Patient Signature: _____ Date: _____

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Additional Patients' Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.

- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore Stanford S. Feinberg, MD, PC and its staff/employees have no responsibility or liability as a result of an redisclosure and (2) such information would no longer be protected by the Privacy Rule.

- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.

- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.

- Stanford S. Feinberg, MD PC cannot require me to sign the Authorization in order to receive treatment.

- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

- In accordance with 35 P.S. §7607 (e) pertaining to HIV-Related Information, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

- I am entitled to a copy of this completed Authorization form.