MID-WEST CENTER FOR SLEEP DISORDERS
www.mwcsd.com

Arshad Abbasi, MD; FCCP; D, ABSM
Diplomate of the American Board of Sleep Medicine
C.M. Gera, MD; FCCP; D, ABSM
Diplomate of the American Board of Sleep Medicine

Ashok Gupta, MD; FACP; D, ABSM
Diplomate of the American Board of Sleep Medicine
Gauresh H. Kashyap, MD; FCCP; D, ABSM
Diplomate of the American Board of Sleep Medicine

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ **DOB:** _____
PLEASE PRINT FULL NAME

1. I authorize the use or disclosure of the above named individual's health information by Midwest Center for Sleep Disorders, MI as described below.
2. The type of information to be used or disclosed is as follows:
   a. Clinic or Progress Note
   b. History and Physical Report
   c. Bill for Service
   d. Procedure Report
   e. Other _____

   The above information can be released for the period of _____ (months/ years)**.**
3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.
4. The information identified above may be used or disclosed to the following individual(s) or organization(s):

NAME OF ORGANIZATION OR INDIVIDUAL:	
ADDRESS:	
PHONE NUMBER:	**FAX NUMBER:**

5. This information for which I am authorizing disclosure will be used for the following purpose:
   a. My personal use ☐
   b. Sharing with other health care providers ☐
   c. Other_____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Midwest Center for Sleep Disorders. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. This authorization will expire on _____. If I fail to specify an expiration date, this authorization will remain valid until I notify Midwest Center for Sleep Disorders in writing.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.
9. I understand the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE *DATE*

_____
IF SIGNED BY A LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF WITNESS *DATE*