HIPAA AUTHORIZATION for the

DISCLOSURE OF MEDICAL INFORMATION/PROTECTED INFORMATION

I, _____, _____ (DOB: ___/___/_____), am the protected person/patient in interest. In accordance with the Federal regulations passed by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act and the Maryland Medical Records Statute, I hereby authorize use or disclosure of protected health information as follows:

1. The Center for Sleep & Wake Disorders is authorized to make the requested use or disclosure of protected information to the person(s) listed on this release.

2. I hereby authorize and direct the disclosure of the following information: any and all information concerning the physical or mental condition and/or medical or other treatment rendered to me and any and all medical records of any nature whatsoever, including but not limited to the patient questionnaires, correspondence, sleep study results, consultations, studies, tests, test results, requests for studies or tests, radiographic studies, MRI's, CT scans, any and all other images or imaging studies of any nature whatsoever, photographs, micrographs, illustrations, diagrams, laparoscopic images, laboratory results, surgical reports or operative reports, pathology results, progress notes, histories, physical exams, nurses' notes, billing statements, invoices, bills, schedules, scheduling documents, ledgers, appointment documents, and any and all other information of any nature whatsoever, in any form whatsoever, whether generated by you or your employees, partners, principals, agents or servants or generated by other persons or entities and received by you for any reason or purpose, whatsoever, regarding me at anytime whatsoever. These communications will be used for the purposes of providing and coordinating care and billing matters. Disclosures will be with authorized parties only, unless a specific exemption exists in the Practice HIPAA Policies.

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying The Center for Sleep & Wake Disorders in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me upon whether or not I sign the authorization.

5. The Center for Sleep & Wake Disorders follows abides by Federal regulations governing protection of electronic protected health information (ePHI) which require that all electronic communication with patients be via our secure patient portal. We do send appointment confirmation emails, which contain no ePHI.

Please list all <u>doctors/practitioners</u> that you would like us to communicate with as described above, with particular attention to general practitioners/primary care, cardiologists, neurologists, psychiatrists, and pulmonologists:

Please list all <u>friends/family members and your relationship</u> that you permit us to communicate with as described above.

_____ ___/___/_____

Signature Date