Southeast Regional Sleep Disorders Center
357 Woodruff Road
Greenville, SC 29607
(864) 62-SLEEP
(864) 627-5337
(800) 290-1349

Disclosure/Release of Protected Health Information

Patient Name: _____ Patient Account Number: _____

Patient Request:

PHI to be copied:
Health: _____ Date range of PHI to be copied: Start date: _____ End date: _____
Financial: _____ Start date: _____ End date: _____
Other: _____ Start date: _____ End date: _____
Purpose of disclosure: _____

Non-patient Request:

PHI to be released:
Health: _____ Date range of PHI to be copied: Start date: _____ End date: _____
Financial: _____ Start date: _____ End date: _____
Other: _____ Start date: _____ End date: _____
Purpose for disclosure: _____

Requestor Information:

_____ _____
Requestor's signature Date

Patient's Authorization:

I understand the potential for information disclosed under this authorization to be subject to re-disclosure by the recipient and may not be protected by HIPPA.
I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this order to receive treatment.
I understand that I may inspect a copy of this information to be used or disclosed.
I understand that I can revoke this authorization in writing at any time and that the revocation will not apply to the extent that Southeast Regional Sleep Disorders Center has taken in reliance on this authorization.
I authorize the use and disclosure of my health information as previously described. Unless other wise revoked, this authorization will expire on the following date, event or conditions:

_____ _____
Patient/Legal Representative's Signature Date

Address PHI to be mailed/faxed:

_____
Street City State Zip

Phone: _____ Fax: _____