EASTERN IOWA
SLEEP CENTER

Medical Records Release of Information

I hereby authorize (name of provider/address):

_____

_____

To disclose the following information from the sleep records of:

Name: _____
Last First MI Previous Name

_____ H _____ W _____
Birth Date Social Security # Telephone #s

Address: _____
Street Apt/Unit # City State Zip

This information is to be disclosed to:

_____

_____

For the purpose of: _____

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Eastern Iowa Sleep Center.
I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the Eastern Iowa Sleep Center. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health, alcohol/drug abuse, HIV/AIDS or all of these. My signature authorizes release of all such information as specified above.

Prohibition On Redisclosure
This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law of alcohol/drug abuse records, by state law for mental health records or HIV/AIDS related records, federal requirements (42 CFR Part 2) and state requirements (Iowa Code chs. 228/141) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse mental health or HIV/AIDS information.

Expiration date: One year from date of signed or date specified: _____

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