­­­­­­­­­­­­ **PATIENT PHI RELEASE AUTHORIZATION**

1. I herby authorize Alabama Sleep and Lung Medicine LLC., its agents, employees, and contractors to release and or disclose all or any part of my private health information (PHI) to and or discuss any aspect of my PHI with (List any names of family members with whom we may release and or discuss your PHI)
2. I herby authorize the release and disclosure of any and all of my PHI to any other individual or entity, including but not limited to any referring physician, hospital, or other health care provider, which in the opinion of the staff or the physician of Alabama Sleep & Lung Medicine, LLC may be assisting in providing or continuing my medical care and treatment, for assisting in any reimbursement of benefits or FMLA/Disability forms.
3. This authorization shall expire at least 2 years from the date indicated below. I understand I may revoke this authorization at any time, in writing, unless Alabama Sleep & Lung Medicine, LLC has relied on this authorization.
4. I understand that information disclosed pursuant to this release may be re-disclosed by the authorized recipient and no longer protected by the privacy rules of Health Insurance Portability and Accountability Act of 1996.
5. I authorize Alabama Sleep and Lung Medicine LLC.,its agents, employees, and contractors to leave messages on my answering machine or voice mail at my home or work, with a secretary, co-worker, or family member regarding appointments or other messages from the physician or office staff.
6. I understand any verbal request I make for my medical records to be released to any entity or person shall be as legally binding as a written request and I shall take no legal actions against Alabama Sleep & Lung Medicine, LLC for releasing any portion of my PHI.

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Patient’s Name Date of Birth

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Patient’s Signature Today’s Date

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Witness Signature

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If the patient is a minor or unable to sign, the complete the following:

\_\_\_\_\_\_\_ Patient is a minor Patient is unable to sign because of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person signing and relationship to the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_