Sleep & Attention Disorders Institute
(Accredited by American Academy of Sleep Medicine)
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Board Certified, Sleep Medicine & Clinical Neurophysiology
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AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

1. By signing below, I hereby authorize my health information, as more specifically described as follows: Medical Records in the possession of Clinical Neurophysiology Services, PC, dba Sleep Disorders Institute/Attention Disorders Institute, R. Bart Sangal, M.D., Director (hereafter known as CNS) (this health information is referred to herein as "Protected Health Information"), to be used or disclosed.

2. The specific person or class of persons who are authorized to use or disclose my Protected Health Information are as follows: Employees of CNS.

3. The persons or class of persons to whom CNS may make the use or disclosure of my Protected Health Information are as follows: _____
_____
_____.

4. This Authorization shall expire on: three years after last contact with CNS.

5. I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if CNS has taken action in reliance upon this Authorization; or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

6. I understand that I may revoke this Authorization by a written request made to CNS.

7. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____	_____
Printed Name (Patient) Date of birth	Signature (Patient/ Authorized Representative) Date
_____	_____
Signature (Witness) Date	Name of Authorized Representative's & Description of Printed authority to sign for the patient