(Accredited by American Academy of Sleep Medicine)
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AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION BY OTHER ENTITIES

1. By signing below, I hereby authorize my health information, as more specifically described as follows: my health information that identifies me, and that consists of my past, present or future physical or mental health or condition, the provision of my health care; and the past, present or future payment for the provision of my health care (this health information is referred to herein as "Protected Health Information"), to be disclosed.

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

3. Authorized person(s) may **disclose my Protected Health Information to** the following persons or class of persons: **Clinical Neurophysiology Services, PC, 44344 Dequindre Rd, Ste. 360, Sterling Hts, MI 48314**.

4. I understand that the purpose of the disclosure of my Protected Health Information is as follows: my treatment.

5. I understand that CNS will not condition treatment on me providing this Authorization to CNS.

6. I understand that I may refuse to sign this Authorization.

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

8. 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.

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

10. I understand that my Protected Health Information that is disclosed under this Authorization may be subject to redisclosure by the recipient and its privacy 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 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