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**PRACTICE OF SLEEP MEDICINE**
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American Board of Psychiatry and Neurology (ABPN)
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# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release information form the record of:
Name of Facility/Person

_____
Patient Name DOB:

TO: _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

For the purpose of (provide a detailed description):_____

Specific information to be released (check all that apply):

- o Consults
- o Medical History & Physical Exam
- o Progress Notes
- o Sleep study reports
- o Laboratory reports
- o EEG reports
- o Radiology reports
- o Psychiatric/Psychological Eval

Dates of information to be released: _____

I understand that this authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to facility/person I authorized above to release the information.

_____
Date of Signature Signature of Patient

_____
Date of Signature Signature of Parent, Legal Guardian or Authorized Representative