GUAM SLEEP CENTER
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AMERICAN ACADEMY OF SLEEP MEDICINE ACCREDITED MEMBER CENTER

Authorization for Release of Medical Information

PATIENT NAME: _____ **DOB:** _____|_____|_____
Last, First M.I. MM DD YYYY

I voluntarily authorize and direct my health care provider, **GUAM SLEEP CENTER,** to provide a copy, summary, or narrative of my medical records (as indicated by the check mark below) or to otherwise release confidential information. I understand that one (1) copy will be provided to me free of charge upon my first request, and there will be a fee for each copy I request thereafter. **This authorization permits the above provider to disclose the following medical records which I am requesting via my preferred method of disclosure:**

□Sleep study results/report □Consultation report □Other

Please select (✓) a method of disclosure.

□ **Pick-up**	*Name of Recipient:*	*Relationship to Patient:*
□ **Fax**	*Name of Recipient/Attn to:*	*Relationship to Patient:*
	Fax#: ( )	
□ **Mail**	*Name of Recipient:*	*Relationship to Patient:*
	Mailing Address *Apt#* *City* *State* *Zip*	

The reason(s) or purpose(s) for this release of information is/are:

Note: *"at the request of the patient" is sufficient if the patient is initiating this authorization*

REDISCLOSURE I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

SIGNED: _____ **DATE:** _____|_____|_____
(Patient or person legally authorized to consent on patient's behalf) MM DD YYYY