920 Copperfield Blvd, NE
Concord, NC 28025
Tel 704-707-4120
Fax 704-706-9520

Authorization to Release or Receive Health Information

By signing this form, I authorize Carolinas Sleep Specialists, P.A. to receive / send the protected information described below:

Name and address or person / organization information should be sent to / from:

____

____

____

Phone: ______________________________ **Fax:**______________________________

Please send the following information:

____

____

I understand that this information may include all medical records and there may be information in these records that I would not want released.
I have been provided a copy of Carolinas Sleep Specialists, P.A. Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release and disclosure of my health information with Carolinas Sleep Specialists, P.A. privacy officer or other personnel.

I understand that Carolinas Sleep Specialists, P.A. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Carolinas Sleep Specialists, P.A. from all legal liability that may arise from this authorization.

Patients Signature:______________________________ **Date:**____________________

Print Name:______________________________

SS #:______________________________ **DOB:**____________________

Witness:______________________________ **Date:**____________________