OMAR TURK, MD





AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize release of health information for the individual named below.

Patient Name	Date of Birth	Social Security Number	
Address (Street, City, State, Zip Code)		Telephone Number	
I authorize Neurosleep Center to release information to:			
(or) I authorize the organization named below to release information to Neurosleep Center:			
	T		
Treatment dates:	Purpose of Reques	St:	
The following information is to be disclosed:		Method of Disclosure (please check one):	
The following information is to be disclosed.		☐ Mail to:	
		☐ Fax to (Medical Facilities Only): Fax #:	
		rax#	
		☐ Call when ready for pick-up:	
		Name:	
		Telephone #:	
Sensitive Information : I understand that the information in m diseases, acquired immunodeficiency syndrome (AIDS), or info			
include information about behavioral or mental health services	or treatment for alcoh	hol and drug abuse.	
Right to Revoke: I understand that I have the right to revoke			
of this form, except to the extent that action has been taken in revoked by me or until it expires, as noted below.	reliance on this author	orization. This authorization is in effect until	
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:			
If I do not specify an expiration date, event or condition, this authorization will expire in six months.			



Redisclosure : If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be redisclosed and no longer protected by these regulations.			
Other Rights: I understand I may refuse to sign this authorization and that my refusal will not affect the use or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.			
I may inspect or copy any information used/disclosed under this authorization.			
Signature of Patient or Legal Representative	Date		
If Signed by Legal Representative, Relationship to Patient			