OMAR TURK, MD

Neurologist- Board Certified

NEUROSLEEP CENTER

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:		
Treatment dates:	Purpose of Request:	

The following information is to be disclosed:	Method of Disclosure (please check one):
_____ _____	❑ Mail to: ❑ Fax to (Medical Facilities Only): Fax #: _____ ❑ Call when ready for pick-up: Name: _____ Telephone #: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, except to the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires, as noted below.

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.

4190 24th Ave, Ste 210, Fort Gratiot, MI 48059 Tel: 810-216-1901 Fax: (810) 216-1701

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	