PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

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Phone: 907.331.3640; Fax: 907.331.3647
peakneurology.com

Authorization For Release Of Health Information

Patient name _____ Patient Date of Birth _____

I authorize the following to disclose health information (*Where records should be sent from*):

☐ Peak Neurology and Sleep Medicine

OR

☐ _____ _____
Individual/Organization name Fax number

To be released to (*Where records should be sent to*):

☐ Peak Neurology and Sleep Medicine ☐ Fax: 907.331.3647

OR

☐ _____ _____
Individual/Organization name Fax number

The information you may release subject to this signed release form is as follows:

☐ Complete records	☐ History and physical	☐ Progress notes
☐ Mental health notes	☐ Lab results	☐ Imaging/diagnostic reports
☐ Therapy reports	☐ Treatment record	☐ Neuropsychology reports
☐ Hospital records	☐ Medication list	☐ Other (specify below)

Please specify studies being requested: _____

Please release information for these treatment dates: _____

The information requested is for the purpose of:

☐ Continuity of care ☐ Personal ☐ Other _____

I have had the opportunity to review and understand the contents of this authorization. I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted infections, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health issues. **Peak Neurology and Sleep Medicine will only release records specifically pertaining to treatment or diagnostic results rendered through this clinic. No records from outside clinics, facilities, or organizations will be released and must be obtained through the original rendering provider.**

I understand that this authorization may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date of my signature. A copy of this authorization will be considered as valid as the original.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below I acknowledge I have read and understand the above policies:

_____ _____
Patient signature Date

_____ _____
Or legal representative (please print) Guardian relationship to patient

_____ _____
Witness Date