HollowBrook Sleep

HIPAA Form

Authorization for Release of Medical Information

_____ _____ _____

FIRST NAME MI LAST NAME

_____ /_____ /_____

BIRTHDATE

_____

ADDRESS CITY / STATE / ZIP

Hereby authorize: HollowBrook Sleep Solutions, LLC and Dr. Lee Smith DDS / Dr. Eric Erlander DDS, permission to release any and all information relating to my medical / dental records, my diagnosis and treatment of sleep disorders and sleep disordered breathing, as well as, my financial information to: all medical entities including any and all sleep service providers, medical insurance and billing services (legal documentation to process claims), and referring or treating physicians or dentists to assist in the evaluation of my suitability for treatment of sleep disordered breathing by mandibular advancement appliance therapy

Consent of Release of Information: I understand that under the Health Insurance Portability and Privacy Accountability Act of 1996 (HIPAA) that I have certain rights to privacy in regard to my protected health information. I authorize the Doctors/Dentists at HollowBrook Sleep Solutions, LLC to release this information to: conduct normal healthcare operations, obtain payment from third party payers, plan my treatment, and follow-up with other healthcare providers if and when indicated.

Change of Insurance Carrier(s) and / or Coverage: I understand that it is my responsibility to inform the staff at HollowBrook Sleep Solutions, LLC of any changes in my insurance carrier and / or coverage. Any changes that are acquired as a result of not informing the staff at these changes are my financial responsibility and must be paid within 30-days of the date of service.

I hereby authorize the direct payment of any insurance benefits, otherwise payable to me, directly to HollowBrook Sleep Solutions, LLC – Dr. Lee Smith DDS / Dr. Eric Erlander DDS.

Receipt of Privacy Policies and Practices: I have received a copy of the Privacy Policies and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing how my private information is disclosed to carry out treatment, or payment by a third-party payer.

I hereby authorize any records, including all medical, financial, and insurance information to be shared with the following people:

_____ _____

NAME RELATIONSHIP TO PATIENT

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE