MIDWEST
Dental Sleep CENTER

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**Denotes board certified Diplomate of the American Board of Dental Sleep Medicine (ABDSM).*

BARRINGTON
27790 W. Highway 22
MOC 1, Ste. 2
Barrington, IL 60010

CHICAGO
150 E. Huron Street Ste. 1103
Chicago, IL 60611

HOMER GLEN
14831 W. 159th Street Ste. 1
Lockport, IL 60491

LOMBARD
2500 S Highland Ave, Ste 220
Lombard, IL 60148

SKOKIE
4711 Golf Rd. Ste. 413
Skokie, IL 60076

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AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE
DENTAL SLEEP MEDICINE *Accredited Facility*

Authorization for Release of Confidential Health Information

Section 1: Patient Information (please print and complete all fields)

First Name: Last Name:
DOB:
Address: City, State, Zip:
Phone:

Section 2: Information Requested

Location of Records:
Dental Sleep Center & Compliant Sleep Solutions ("the Company")
14831 W 159th St, Ste 1-3, Lockport, IL 60491

Select the specific information to be disclosed. "All Records" or "All Dates" is not specific.

Dates of Service:
☐ Progress Notes ☐ Sleep Study Reports ☐ Imaging ☐ Test Results
☐ Other:

Section 3: Individual/Provider/Entity Receiving Records

Name:
Address:
Phone: Fax:
Email:

Section 4: Purpose for Disclosure

☐ Application for Insurance ☐ Legal Claim/Lawsuit
☐ Continuation of Care ☐ Disability Claim
☐ Other:

Section 5: Signature(s)

- I understand the information to be released may include information relating to the diagnosis and/or treatment of acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental and/or behavioral health, drug and/or alcohol abuse. Please check here to exclude this info: ☐
- I understand I have the right to inspect and copy the information disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand it will not be disclosed, except as provided by law.
- I understand the company does not condition treatment on whether I sign this authorization, except as necessary for payment of claims or provision of health care solely for the purpose of creating protected health information for disclosure to a third party (DOT or pre-employment exams, etc).
- I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand there may be charges for completing forms and/or releasing records and imaging requested on this authorization.
- I understand I may revoke this authorization at any time by giving written notice to the company at 14831 W 159th St, Ste 1, Lockport, IL 60491. Revocation will not apply in cases where the company has already relied on this release for previous disclosure.
- This document expires in one (1) year or upon the following specified date/event:

_____ _____
Signature of patient or legal representative *Date*

_____ _____
Signature of Witness *Date*

Email this form to Insurance@MidwestDentalSleepCenter.com