HIPAA Release and Consent for Voluntary Disclosure of Sleep Study Results

Patient Name: _____

Date of Birth: _____ **Phone:** _____

Email: _____

Purpose of Form: This form authorizes the voluntary release of home sleep apnea study results by Online Home Sleep Study and its clinical team to a designated third party, such as a Department of Transportation (DOT) medical examiner or employer.

Important Note: You are not required to disclose your sleep study results unless you choose to do so. Results from tests ordered voluntarily by you (the patient) through Online Home Sleep Study will remain private unless this form is signed and submitted.

By signing this form:

- I understand that my home sleep study was self-ordered and not required or requested by a DOT medical examiner.
- I authorize Online Home Sleep Study to release my test results and any related documentation to the following recipient(s):

Recipient Name or Clinic: _____

Relationship (e.g., DOT Medical Examiner, Employer): _____

Phone or Fax (if available): _____

Email (if applicable): _____

This authorization covers the disclosure of the following:

- Completed sleep study results (PDF)
- Physician interpretation (if available)
- Any other relevant consultation notes related to this test
- FAA letter (if requested)

Expiration and Revocation: This release is valid for one year from the date signed below. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it. Fax signed form to 877 722 1537.

Signature of Patient: _____ **Date:** _____

Printed Name: _____