KAIROS SLEEP CLINIC

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Board Certified Sleep Medicine | Tel: (385) 267-7863 | www.kairossleepclinic.com

1. PATIENT IDENTIFICATION

Patient Legal Name: _____ **Date of Birth:** _____ **Phone:** _____

Address / City / State / Zip: _____

2. DISCLOSING HEALTHCARE PROVIDER / FACILITY

Facility / Provider Name: _____ **Phone / Fax:** _____

Facility Address / City / State: _____

3. RECIPIENT ENTITY (SEND RECORDS TO)

KAIROS SLEEP CLINIC (Kairos Health PLLC) | Attn: Medical Records & Intake
Email / Secure Portal: info@kairossleepclinic.com | Phone: (385) 267-7863 | www.kairossleepclinic.com

4. INFORMATION TO BE RELEASED (Check all that apply)

- ☐ Polysomnography (PSG) & Home Sleep Apnea Test (HSAT) Reports & Raw Data
- ☐ Positive Airway Pressure (PAP/CPAP) Compliance Downloads & Titration Studies
- ☐ Sleep Medicine Consultation Notes, Progress Notes, & Clinical Evaluations
- ☐ Current & Past Prescription Lists, Medication Histories, & Pharmacy Notes
- ☐ Relevant Pulmonary Function Tests (PFTs), Chest Imaging, & Cardiac/ENT Reports
- ☐ Entire Clinical Sleep Medicine Medical Record (Past 3 Years)

5. PURPOSE OF DISCLOSURE

Continuity of care, comprehensive clinical sleep evaluation, diagnostic verification, and ongoing treatment planning.

6. PATIENT ACKNOWLEDGMENTS & SIGNATURE TRANSFER AGREEMENT

Voluntary Authorization: I understand that granting this authorization is voluntary. My treatment, payment, or enrollment will not be conditioned upon signing this document.

Revocation: I may revoke this authorization in writing at any time. Revocation will not apply to records already disclosed in reliance on this authorization prior to written notice.

Digital Signature Transfer: As authorized in my signed Kairos Sleep Clinic intake and consent documentation, I consent to the transfer and application of my electronic signature to this Release of Information form for the administrative purpose of requesting my sleep and clinical records from outside providers.

Expiration: Unless revoked earlier in writing, this authorization has no expiration date and shall remain valid indefinitely.

7. PATIENT / REPRESENTATIVE SIGNATURE

Signature of Patient / Legal Rep: _____ **Date Signed:** _____