THIBODAUX REGIONAL HEALTH SYSTEM
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME_____ **DATE OF BIRTH**_____

This is to authorize_____to release
Name of Hospital/Physician
to **THIBODAUX REGIONAL SLEEP DISORDERS CENTER**
Name of Hospital, Physician, or Third Party
604 N ACADIA ROAD., SUITE 210, THIBODAUX, LA.
Complete Mailing Address
Telephone Number **985-493-4759** Fax Number **985-449-2525**

Type or record requested:	**Inpatient**	**ODS**	**Outpatient**	**ER**
Facesheet	Consultation		History and Physical Report	
Operative Report	Physician Progress Notes		Discharge Summary	
Lab/X-Ray Reports	Complete Hospital Record		Other_____	

Covering the period of hospitalization/treatment from_____to_____.
_____I will review records at Thibodaux Regional Medical Center.
_____I wish to have my records copied and I will pick them up at the facility.
_____I am requesting that the facility copy my medical records and mail the records to the above address.

I understand that the information indicated above is considered confidential and is to be utilized by the recipient only for the following purpose:

Continued Treatment Processing/Application of Insurance/Benefits
Employment Legal Other_____
Specify other limited purpose

I understand that the medical record may contain information relating to psychological/psychiatric conditions, alcohol or drug abuse, AIDS testing or testing for the HIV antibody or antigen and/or genetic testing. I understand that I have the right to refuse to disclose psychological/psychiatric conditions, alcohol or drug abuse, HIV test results and/or genetic testing. I specifically authorize release of the following types of information:

☐ Psychological/psychiatric conditions ☐ Alcohol or drug abuse
☐ AIDS testing or testing for the HIV antibody or antigen ☐ Genetic testing

I further understand that I am not giving permission for any re-disclosure other than the specified above. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I hereby waive and release the above named hospital, physician(s), and any member of their staff from any restriction or privilege imposed by law in disclosing or revealing any professional record, observation, or communication.

This authorization is subject to revocation at any time except to the extent that the releasing party has already taken action on it. The revocation must be in writing and delivered to the Health Information Management Department. If not previously revoked, this authorization will terminate 90 days from the date of my signature.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain further treatment from Thibodaux Regional Medical Center, nor will it affect my eligibility for benefits.

I do hereby expressly and voluntarily consent to disclosure of the medical record information for the purpose or need as stated above.

***** _____ _____
Signature of patient or authorized legal representative **Date**

_____
Relationship

Verbal consents require (2) witnesses' signatures indicating consent but unable to provide signature.

_____ _____
Signature of witness/relationship to patient or credentials Date

_____ _____
Signature of witness/relationship to patient or credentials Date

Berlin Questionnaire

Sleep Evaluation in Primary Care

THIBODAUX REGIONAL SLEEP DISORDERS CENTER

Accredited by the American Academy of Sleep Medicine

985.493.4759

Please Complete the following:

height_____ age _____

weight_____ male/female _____

Category 1

1. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

2. Your snoring is?

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

3. How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

4. Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

5. Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

Category 2

6. How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

7. During your waketime, do you feel tired, fatigued or not up to par?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

if yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

Category 3

9. Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

Scoring Questions: Any answer within box outline is a positive response.

Scoring categories:

- ☐ Category 1 is positive with 2 or more positive responses to questions 1-5
- ☐ Category 2 is positive with 2 or more positive responses to questions 6-8
- ☐ Category 3 is positive with 1 positive responses to questions 9-10

Final Result: If 2 or more possible categories are positive, you have a high likelihood of sleep apnea.

Name _____

Address _____

_____