AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize:

Georgetown Sleep Center, P.A.
3121 Northwest Blvd.
Georgetown, TX 78628
Ph: (512) 868-5055 Fax: (512) 868-5077

To release information from my medical record to:

Physician: _____ Physician: _____
Address: _____ Address: _____
Ph: _____ Fax:_____ Ph: _____Fax: _____

The purpose of this request is for:

_____Medical Care _____ Legal Matters _____Other (Specify)
_____Insurance Claim _____ Personal Issues _____

Information to be released:

_____ History and Physical/Consultation Visit
_____ Progress Notes
_____ Sleep Study Reports
_____ Laboratory
_____ Other (Specify) _____

Name of Patient: _____
Address: _____
Date of Birth: _____
Social Security Number: _____
Telephone Number: _____

This authorization shall expire 60 days from the date of signing, and may be revoked, verbally or in writing, by the patient at any time prior to the expiration date, but not made retroactive to any information already release with authorization. Copies will be completed within 15 days of receipt of a valid written request. The request must specify the records desired.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Georgetown Sleep Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. Copies will be completed within 15 days of receipt of a valid written request. The request must specify the records desired.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date