

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize:

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

To release information from my medical record to:

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

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: _____ Fax 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.

Patient/Guardian Signature

Date

Witness Signature

Date