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