AUTHORIZATION TO RELEASE INFORMATION

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

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:

Person/class of person/facility: _____
Address: _____
Phone: _____
Fax: _____

Person/class of person/facility: _____
Address: _____
Phone: _____
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) _____

- This authorization expires 1 year after the date signed, OR upon occurrence of the following event or to the purpose of the intended use or disclosure of information:
  _____
- This authorization may be revoked by notifying Georgetown Sleep Center in writing. However, any action already taken in reliance on this authorization cannot be reversed and any revocation will not affect those actions.
- Treatment, payment, enrollment or eligibility of benefits will not be conditioned on this authorization.
- Information disclosed to recipient may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

_____ _____
Signature of Individual Date
Or if applicable-

_____ _____
Signature of Guardian or Personal Representative of Patient's Estate Date

*If signed by Personal Representative – Description of Authority to sign:

_____