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: _____

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