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: _____

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date