AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: _____
Address: _____
Date of Birth: _____
Social Security Number: _____
Telephone Number: _____ Fax Number: _____

I hereby authorize:
Person/class of person/facility: _____
Address: _____
Phone: _____ Fax:_____

To release information from my medical record to:

Georgetown Sleep Center
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) _____

- 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.

_____ _____
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:

_____