AUTHORIZATION TO RELEASE INFORMATION

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

I hereby authorize:

Georgetown Sleep Equipment & Supplies
3121 Northwest Blvd.
Georgetown, TX 78628
Ph: (512) 868-5044 Fax: (512) 868-1062

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 Equipment & Supplies 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:

_____