Commonwealth Sleep Center

Ph: (571)261-9877 Fax: 703 992 9266

Authorization for Release of Medical Information

www.commonwealthsleepcenter.com

Personal Information

Social Security #:_____ Date of Birth: _/ _/ _____ Age:_____ Sex: M F

Patient's Name: Last_____ First_____ Mi_____

Patient's Address:_____ Apt#:_____

City:_____ State:_____ ZIP:_____

Home Telephone:_____ Work Telephone:_____ Ext_____ Cell:_____

(Please check the information you are requesting)

___ Office Visit Notes ___Sleep study Reports ___ All Records

I _____, do hereby authorize Commonwealth Sleep Center to release or get
(Patient's Name)

Please Circle on Opinion: **Release or Get Records From**

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Purpose of Disclosure:

_____ I do, _____ NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessments and treatment for alcohol and / or drug abuse

I hereby authorize disclosure of the health information above. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation, I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations.

_____ _____
Signature of Patient/Guardian/Legal Representative Today Date

****** Note: There will be a charge for personal copy and permanent transfer of your records *****