ALLISON
& ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The execution of this form does not authorize the release of information other than the terms specifically described below.

TO: _____ PATIENT NAME: _____
FAX: _____ DOB: _____
RELEASE TO: _____

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual names on this request. I understand that the information to be released include information regarding the following conditions(s):

INFORMATION REQUESTED & DATES:
Copy of medical chart relating to sleep disordered breathing: _____
Sleep studies: (one within a year) _____
Test results relating to sleep disordered breathing: _____
Treatment rendered for alleviation of sleep disordered breathing: _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:
The fabrication and delivery of DME relating to the diagnosed sleep disordered breathing, and the associated post-operative care.

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in and event: on _____ (date supplied by patient); or _____ if revoked in writing by patient; or _____ 180 days from the date hereof; _____ or under the following conditions: _____*
_____

A COPY of this Authorization or my signature thereon ___ may, or ____ may not be used with the same effectiveness as an original.
PATIENT NAME: _____
PATIENT SIGNATURE: _____
Person authorized to sign for patient (state how authorized): _____
SIGNATURE DATE: _____