5508 Parkcrest Dr., Suite 200 Austin, Texas 78731
512-697-9896 - Fax 512-697-9895

Medical Release

The Sleep Center of Austin

Patient Name: _____
Print Name

DOB:_____ SS# (last 4 numbers) _____

If minor, Parent Name:_____
Print: Last First MI

By signing this form I authorize The Sleep Center of Austin to release confidential health information about me to the person(s) or entity listed below.

- ❑ Confer with person listed below orally about my medical information

Release my protected health information to the following person(s)/entity:

Name (please print): _____

Street:_____

City: _____ State: _____ Zip:_____

Please list any information that you prefer this party not receive:

_____

The reason(s) or purpose(s) for this release of information are as follows:

_____

This release is to be in effect **until I contact the office to terminate**.

Signature of Patient or Legal Representative**:** _____ Date:_____

Relationship to patient: _____

If Guardian, relationship to patient:_____

Witness: _____ Date:_____