

AUTHORIZATION TO RELEASE INFORMATION TO DEARBORN SLEEP LAB
Division of Millennium Medical Group South, P.C.

I hereby authorize:

Name of Facility

Address

Phone

Fax

to release the records noted below to:

Dearborn Sleep Lab
18100 Oakwood Blvd., Suite 310
Dearborn, MI 48124
Phone 313-438-9800 • Fax 313-438-9801

The purpose of this request is for:

- | | | |
|--|--|--|
| <input type="checkbox"/> Medical care | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Insurance claim | <input type="checkbox"/> Personal issues | _____ |

Information to be released:

- | | |
|---|--|
| <input type="checkbox"/> History and physical | <input type="checkbox"/> Sleep study reports |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Questionnaires | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Progress notes/follow-up letters | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Physician's orders | _____ |

Patient Name _____

DOB _____ Name at time of treatment _____

Telephone number _____

Address _____

This authorization shall expire one year from the date of signing and may be revoked by the patient verbally or in writing at any time prior to the expiration date, but not made retroactive to any information already released with authorization.

Patient/Guardian Signature

Date

Witness Signature

Date

This information has been disclosed from records whose confidentiality may be protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit medical providers from making further disclosure of this information except with the expressed, written consent of the person to whom it pertains. A general authorization for release of information, if held by another party, is insufficient for this purpose.