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# The Center for Respiratory and Sleep Disorders

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44000 West 12 Mile Road, Suite 113, Novi, MI 48377 **248.465.9253 (WAKE)**

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## Authorization for Release of Information to Family Member or Friend Without Power of Attorney

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I, \_\_\_\_\_ (patient), hereby give the following person(s) authorization to obtain information regarding my:

\_\_\_\_\_ Confirm appointments and leave messages

\_\_\_\_\_ Lab Work/Test Results

\_\_\_\_\_ Medical Records Information

\_\_\_\_\_ Billing Information

\_\_\_\_\_ **ALL** of the above

Person 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person 3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person 4: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person 5: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I, \_\_\_\_\_ (patient), hereby authorize **The Center for Respiratory and Sleep Disorders** to leave a message on the telephone numbers I have given to them to contact without exception of the person answering the telephone.

\_\_\_\_\_ ACCEPT

\_\_\_\_\_ DENY

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Signature of Patient

Date

**THIS REQUEST VALID FOR 1 YEAR FROM DATE ABOVE**