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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.WAKE

## Authorization to Release Medical Information

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Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

I authorize, \_\_\_\_\_ to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).

Name to whom information may be released \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Date of Information Requested \_\_\_\_\_ of **ALL** Records

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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation unless otherwise enforced by law.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_