SOMNUS
SLEEP CLINIC
www.somnussleepclinic.com

1006 Treetops Blvd. Suite 102
Flowood, MS 39232
Phone 601-939-1808 Fax 601-939-3828

Authorization for Release of Health Information

Name of physician/dentist or hospital authorized to release information:

_____

Patient information whose health information is to be released:
Name: (Last) _____ (First) _____ (Middle Initial) ____

Address: _____

City: _____ State: _____ Zip _____

SS# _____/_____/_____ DOB: _____/_____/_____

Reason for the release: _____

Description of the health information to be released:

_____

Unless otherwise indicated, permission to release the information expires in six (6) months from the date it is signed. The information released could potentially be released again by the person receiving it. The person giving their permission to release this health information has the right to take their permission away at any time. If you do so, it does not effect the information that has already been released.

Somnus Sleep Clinic will not refuse to treat you if you do not sign this form. I have clearly read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition, including any and all alcohol and/or drugs abuse treatment records to those persons or agencies listed above.

_____ _____

Signature of Patient or Guardian **Date**

Revised April 25, 2017