FOCUS sleep centers

Patient Registration

RELEASE OF INFORMATION CONSENT FORM

Check either or both boxes:

☐ I authorize Focus Sleep Centers to RELEASE medical records information to the below listed parties:

☐ I authorize Focus Sleep Centers to OBTAIN medical records information from the below listed parties:

List entities that we may release or recieve records to/from:

_____

Initials in the blanks below indicate your understanding and agreement:

_____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked it shall terminate six months from the date of consent without express revocation.

_____ I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

_____ I further understand that I have a right to receive a copy of this authorization upon request.

Reason for Release: _____

Copy Requested: ☐ Yes ■ No Copy Received: ☐ Yes ☐ No

Identifying Information:

Patient's Name at Time of Study: _____

Attending Physician: _____

Date of Birth: _____ Date of Treatment: _____

Information Requested:

☐ Discharge Summary ☐ History and Physical ☐ Operative Report ☐ X-ray

☐ Consultation ☐ Laboratory ☐ EKG, EEG ☐ Other: _____

Signed:

Patient, Parent or Legal Guardian: _____ Date: _____

**Your typed signature will serve in lieu of a handwritten signature*

AddressCity/State/ZIP: _____

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Southaven, Mississippi 38671

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