Medical Information Release Form

(HIPAA Release Form)

Patient Name: _____(your name) Date of Birth: _____/____/_____

You must Fax or mail this form To: _____(place or doctor where previous sleep studies have been done)

Release of Information

I authorize the release of information including **ALL SLEEP STUDIES**, the diagnosis, records, examination rendered to me.

This information may be released to:

Dr. Scott Warner

Chest Medicine of Cullman

1890 AL Hwy 157, Suite 420

Cullman, AL 35058

Fax: 256-739-7052

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____(your signature) Date: ____/____/_____

Witness:_____(another person who saw you sign this) Date: ___/____/_____