AUTHORIZATION FOR RELEASE OF INFORMATION

to/from

TRIANGLE NEUROLOGY and SLEEP LAB, PA
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I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the release information may no longer be protected by federal privacy regulations.

Patient Name: ____DOB: ____________________________

Persons/Organizations providing the information: ____________________________________
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Persons/Organization receiving the information: ____
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Specific description of information (including date):

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____ Date________________________

Signature of patient or patient's representative ____

Printed name of patient's representative: ____

Relationship to patient: ____