SLEEP HEALTH INSTITUTE

HELENE A. EMSELLEM, MD
MEDICAL DIRECTOR
240-560-2230

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____, _____

DOB: _____/_____/_____

Daytime Phone: (____)_____-_____

Patient address: _____

I authorize: The Sleep Health Institute / Helene A. Emsellem, MD
10221 River Rd #61324, Potomac, MD 20859
Phone: 240-560-2230
Fax: 1-800-886-1005

To release to: _____

_____

_____

☐ Complete medical records

☐ Other (please specify): _____

_____

This authorization is given for the purpose of continued treatment.

I understand that I may revoke this consent at any time except to the extent that action has been already been taken in response to this request.

_____ _____
Signature of patient or responsible party Date

If this release pertains to alcohol or drug abuse information, please note that: this information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42 C.F.R., Part 2) prohibits you from making further disclosures of it without specific written consent of the patient to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical and other information is NOT sufficient for this purpose.

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