REM DIAGNOSTICS
SPECIALISTS IN SLEEP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____

I request and authorize REM Diagnostics, Inc. to release healthcare information to the following provider:

Name:_____

Address:_____City_____

State_____ Zip Code_____

Phone: _____Fax_____

This request and authorization applies to **(please check)**:

- Healthcare information relating to the following treatment, condition, or dates:_____ _____
- All Healthcare information

I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above. **Yes or No (please circle)**

I understand that I may cancel this consent at any time by writing REM Diagnostics, Inc., but that cancelling it will not affect any information that has already been released. This authorization will expire when I cancel it in writing or on _____.

_____ _____
Patient name (print) Date

_____
Patient signature