Sleep Wellness Clinics of America, PLLC
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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.
You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize **Sleep Wellness Clinics** to release my records and any information requested to the following individuals.

1 _____Relation to Patient:

2._____Relation to Patient:

Authorization Regarding Messages (please check all that apply)

__ I authorize you to leave a detailed message on my home or cell number regarding appointments

__ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____

Patient/Parent's signature Date :

Name: _____