The Connecticut Center for Sleep Medicine
Of the Stamford Health System
The Stamford Hospital
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AUTHORIZATION FOR RELEASE OF RECORDS

I, the undersigned patient or legal representative, hereby authorize The Pulmonary Associates of Stamford, PC, and the CT Center for Sleep Medicine, to use or disclose health information including, if applicable, information relating to the diagnosis and/or treatment of a sleep disorder.

Patient name:_____ Date of Birth:_____

The information may be disclosed and used by the following:

Name:_____
Address:_____
_____
Fax:_____
Phone:_____(if known)

The purpose of this disclosure or use is for:

☐ Medical ☐ Legal ☐ Disability ☐Insurance

☐ At the request of the patient or legal representative

☐ Other

This authorization will be valid for a period of one year from the date. I understand that I may cancel this authorization at any time by writing to the CT Center for Sleep Medicine, but if I do it will not have any effect on records disclosed prior to receipt of cancellation.

Minor patients must have parent or legal guardian's signature.

_____
Patient or Authorized Representative

_____
Relationship

Date:_____

_____
Witness