Good Night Sleep Center
3711 Veterans Blvd.
Del Rio, TX 78840

RELEASE OF CONFIDENTIAL INFORMATION

For the purpose of diagnosis and therapy

TO: ____

I hereby authorize you to release:

Good Night Sleep Center
3711 Veterans Blvd.
Del Rio, TX 78840
(830) 765-1739 (830) 765-7285

The complete records in your possession concerning my history, physical examination, x-rays, and any other reports subject to the following limitations:

A photocopy of this authorization shall be valid as the original. I understand that I have the right to request a copy of this authorization. This authorization shall remain in effect no longer that one year from this date:

DATE: ____

PATIENT: ____

SIGNED: ____

DOB: _______________________ SS# ____

WITNESS: _________________________________ DATE: _______________________