Athena Medical Clinic and Sleep Medicine Associates
Release of Medical Information Consent

Patient's Name _____ dob _____
Street Address _____
City, State, Zip _____ , _____ , _____
Patient's SSN _____ - _____ - _____ Phone # _____

❑ I authorize Athena Medical Clinic and Sleep Medicine Associates to release information to:
Provider or Facility _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

❑ I authorize Athena Medical Clinic and Sleep Medicine Associates to obtain information from:
Provider or Facility _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Purpose for this request ❑ Healthcare ❑ Insurance coverage ❑ Personal ❑ Other

Type of Records Requested ❑ All medical records ❑ Other _____
❑ Specific Illness/Injury ❑ Treatment Dates _____

Authorization Valid (check one) ❑ This request only ❑ Effective until _____ (date)
❑ One year from the date of this authorization

I understand:
My right to healthcare treatment is not conditioned on this authorization.
I may cancel this authorization at any time by submitting a written request to the healthcare provider, except when a disclosure has already been made in reliance on my prior authorization.
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
There may be a charge for the requested records.

_____ _____
Patient's Signature Date

_____
Relationship (if requester is not the patient)