AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Phone #: _____

Current Address: _____ City, State, Zip: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Ashwin Gowda MD

Address: 1221 W Ben White A100

City: Austin State: TX Zip Code: 78704

Fax: 512-440-5858 Phone: 512-440-5757

This request and authorization applies to:

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

_____

☐ All healthcare information

☒ Sleep study results dated from : ANY ON FILE

☐ Other: _____

REPORTS MAY INCLUDE INFORMATION ON DRUG, ALCOHOL, PSYCHOLOGICAL, OR COMMUNICABLE TREATMENT. I WAIVE THE PRIVILEDGE OF CONFIDENTIALTITY OF SUCH INFORMATION. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE ENTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE ON IT AND THAT, IN ANY EVENT, THIS AUTHORIZATION EXPIRES AUTOMATICALLY IN NINETY DAYS FROM THE DATE OF THE SIGNATURE OR AS OTHERWISE SPECIFICIED.

Patient Signature: _____ Date Signed: _____