



**AUTHORIZATION TO RELEASE INFORMATION  
TO/FROM THE SLEEP CENTER**

I, \_\_\_\_\_,  
(Patient/Guardian)

Hereby authorize Eastlake Sleep Center to release/request medical information  
to/from the medical chart of:

\_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Patient/Guardian Signature)

\_\_\_\_\_  
(Date)

*This information has been disclosed from records whose confidentiality may be protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit from making further disclosure of this information except with the expressed written consent of the person to whom it pertains. A general authorization for release of information, if held by another party, is not sufficient for this purpose.*