THE INSOMNIA AND
SLEEP
INSTITUTE OF ARIZONA
PURVEYOR OF GOOD DREAMS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Please check one only:

☐ I only want my medical information released to myself.

☐ I give The Insomnia and Sleep Institute of Arizona and staff authority to release medical information regarding my care to the individuals listed below. This authority will be in effect for one (1) year.

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Patient Signature: _____ Date: _____

Witness: _____

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