Better Sleep, Better Health, Better Life

Advanced Sleep Centers
Patient Authorization for Release of Medical Information:

I, _________________________________, give Advanced Sleep Centers (ASC) my permission to release to the following family member(s)/ friend(s) information from my medical record in my absence. This release will apply to ASC, any doctors and their staff who provide services to ASC, and any durable medical equipment company (DME) staff used to supply medical equipment to me. Unless otherwise noted, this release allows the above entities to leave messages on my answering machine/voice mail, with whoever answers my home phone, and to call me at work.

Name	Relationship to Patient
__________________________________	________________________________
__________________________________	________________________________

Exceptions:____
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Authorization for Release of Medical Records to process Insurance claims:

I further hereby authorize Advanced Sleep Centers to release any medical information necessary to process my insurance.

I hereby authorize payment directly to the provider of services (ASC) and I understand that I am financially responsible for charges not covered by this authorization.

A fee may be charged on all accounts, which are 90 days or more past due at a rate of ½ percent per month. I understand that the ½ percent per month may be added to any account I have that is 90 day or more past due, and herby agree to pay such charges if levied. I also understand that in the event my account is placed with a collection agency and additional fees over and above the balance, plus any and all court costs that may ensure will be added to my account balance.

I have read all of the above, and hereby give my permission to Advanced Sleep Centers to release my medical information/records:

X_______________________________________ Date___________________

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Print Name