Release of Medical Information

Federal Law requires that all patients give written consent to release personal information. This applies to other staff, physicians, family members, or any other entities. Please list the physicians or other individuals you would like DELTA WAVES to be able to communicate your Medical Information with. The information authorized for release may include records which indicate the presence of a communicable or venereal disease including the Human Immunodeficiency Virus (HIV).

Health Care Professionals	**Family Members or Other Individuals**
_____	_____
_____	_____
_____	_____

☒Continuous Positive Airway Services, Inc. (CPAS) or other medical equipment providers for the purpose of acquiring treatment for sleep-related breathing disorders.

Exceptions or Restrictions

Any specific entity/individual or information that you would like restricted from being released

_____

_____

I, _____, hereby authorize DELTA WAVES to release and communicate information regarding appointments, insurance, health care, demographics, and any other personally identifiable information, to the persons and/or entities that have been indicated above, unless specified otherwise, and in respect to any exception or restriction.

_____ _____

Patient Signature Date

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