diamond dental
SLEEP SOLUTIONS

Authorization to Release Medical Information

2983 Long Beach Road, Oceanside, NY 11572
Direct. 516.778.9296 | Fax. 516.232.9530

Date:____/____/_____ Date of Birth: ____/____/_____ SSN: _____

Patient Name: _____

Address: _____City/State/Zip:_____

I, the undersigned, do hereby grant permission for **Dr. Asher Diamond** to

☐ obtain from or ☐ release to:

_____

(Name of person or institution the information will be coming from)

_____

(Address of person or institution the information will be coming from)

The following information from the patient's clinical record:

☐ All necessary medical records

☐ Other: _____

I understand that this information will be used for the purpose of:

☐ Providing information to allow care to be provided to the patient

☐ Supporting the payment of an insurance claim

☐ Other: _____

This authorization will be valid for the period of twelve months unless otherwise specified below.

I understand that I may revoke this consent at any time by sending a written notice. I understand that any release which has been made prior to my revocation which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the above named health care provider.

Signature of Patient or Patient's Authorized Representative _____

Relationship to Patient:_____ Date:_____

Specific authorization for release of information protected by state or federal law - I specifically authorize, by writing my initials beside the category and signing below, the release of data and information relating to:

☐ Substance abuse ☐ Mental Health ☐ AIDS/HIV

Signature of Patient _____ Date:_____