diamond dental
SLEEP SOLUTIONS

Authorization to Release Medical Information

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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.

Signature of Patient or Patient's Authorized Representative _____

Relationship to Patient:_____ Date:_____