300 B Princeton Hightstown Rd.
E. Windsor NJ 08520 Suite 205
Phone: (609) 490- 1444
Fax: (609) 490 -1133
cmdsleep@live.com

CMD
Sleep Disorders Center

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Today's Date: ____________________

Patient Information

Patient Last Name: ______________________ First Name: ______________________ MI: _____

Social Security Number: _____ - ____ - _______ Date of Birth: ________________ Sex: ☐M ☐F

Address: ____

City: _________________________ State: ______ Zip: ______________

Home Phone: (____)________________ Cell Phone: (____)________________ Work Phone: (____)_________________

Disclosing Facility

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility / Physician Name: ____ Phone: (____)________________

Address: ____Fax: (____)___________________

____

Dates and Types of Information Requested

Check One:

- ☐ Last two office clinical notes
- ☐ Referral
- ☐ Complete Chart
- ☐ Script for: ________________
- ☐ Abstract Chart (includes Face Sheet, History & Physical, Consultation, and Discharge Summary)
- ☐ Other: ____

Receiving Facility

Above listed patient authorizes the following facility to receive record disclosure:

Comprehensive Medical Diagnostics, LLC (*CMD Sleep Disorders Center)*
300B Princeton-Hightstown Rd
Suite 205, East Windsor, NJ 08520
Phone: (609) 490-1444
Fax: (609) 490-1133

This disclosure is made for the purpose of ____

e.g. further care, insurance claim, personal, legal counsel, etc.

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I permit a copy of this release to be used in place of the original.

Signature: ____ Date: ____________________

Parent/Guardian Signature: _____________________________________ Date: ____________________