

SLEEP & LUNGS

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Authorization to Schedule Testing/Office Visits/Medical Information and Results of Progress or Prognosis

Patient Name: _____ Date of Birth ____/____/____

I authorize Sleep & Lungs to talk to the following people regarding my scheduling, office visits, medical information and results if I am unavailable:

- No one other than myself
- My Spouse (name of spouse) _____
- My Children (name of children) _____
- Message on my answering machine/voicemail at the following number(s)/ or any other phone number

I understand that this statement will remain in effect until I notify Sleep & Lungs in writing of any changes.

Patient Signature _____ Date _____