RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any information, including medical and billing information by NorthStar Sleep Center to my referring physician, insurance company, and immediate family on behalf of myself and/or my dependents.

Signature: ______________________________ Date: ______________

WORKER'S COMPENSATION / AUTO ACCIDENT

Date of Injury: ______________________________

Insurance Name: ____

Address: ____

City: ________________________ State: ________ Zip: ______________

Phone: ______________________________________

Claim/File Number: ____________________________

Contact Person: ______________________________

SKILLED NURSING FACILITY / HOSPICE

Is the patient currently a resident in a skilled nursing facility or hospice?

Yes ______ No: ______

If Yes, please provide name and address of facility.

Facility Name: ____

Address: ____

City: ________________________ State: ________ Zip: ______________

Phone: ______________________________________

11/2011-dl