DR. CLIFTON HUNT, M.D.
Sleep Clinic of Delaware

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HEALTH INFORMATION RELEASE AUTHORIZATION FORM

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____

Release Information

☐ I authorize Dr. Clifton Hunt's Office to **RELEASE** medical record information to:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____ (required)

Information Needed:

☐ Test Results _____
☐ Progress Notes from date _____ to _____
☐ Laboratory Results _____

Purpose for Request:

☐ Personal Use ☐ Continued Care ☐ Attorney ☐ Insurance Claim

Patient's Signature: _____ Date: _____