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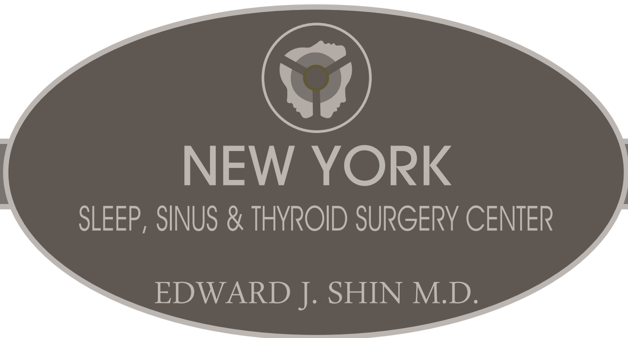

PATIENT RELEASE OF MEDICAL INFORMATION

We need your written permission to indicate your wishes in each of the following areas. Please circle yes or no to indicate your choice.

The physicians and surgeon, and/or their staff, of New York Sleep, Sinus & Thyroid Surgery Center may release verbally or in writing medical information to a pharmacy as required to prescribe medications or obtain authorization by your insurer. ☐ Yes ☐ No

The physicians and surgeon, and/or their staff, of the New York Sleep, Sinus & Thyroid Surgery Centermay release verbally or in writing medical information to your insurer as part of scheduling surgery, performing laboratory tests or other tests, admitting you to the hospital, or providing medical care.

☐ Yes ☐ No

The physicians and surgeon, and/or their staff, of the New York Sleep, Sinus & Thyroid Surgery Center may release verbally or in writing medical information to my employer. This release includes: 1) releases to return to work, 2) insurance forms related to medical coverage or workers' compensation, and 3) letters indicating medical reasons for doctor's appointments or other reasons leading to missed days of work. ☐ Yes ☐ No

The physicians and surgeon, and/or their staff, of the New York Sleep, Sinus & Thyroid Surgery Center may discuss my medical condition with other physicians involved or to be involved in my medical care. ☐ Yes ☐ No

Signature:______________________________ Date:______________________________

Other Instructions:______________________________