THE CENTER FOR sleep & wake DISORDERS

Helene A. Emsellem, MD
Medical Director

John R. Ruddy, MD Linda Croom, ANPC Annemarie Zabbara, PA-C Tina Sullivan, ACNP-BC

ACCREDITED MEMBER CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____, _____

DOB: ___/___/_____

Daytime Phone: **(_____)_____-_____**

Address: _____

_____

I authorize: Helene A. Emsellem, MD
5454 Wisconsin Ave #1725
Chevy Chase, MD 20815
Phone: (301)654-1575 / Fax: (301)654-5658

To release to: _____

_____

_____

☐ Full medical records

☐ Other (please specify): _____

_____

This authorization is given for the purpose of continued treatment.

I understand that I may revoke this consent at any time except to the extent that action has been already been taken in response to this request.

_____ ___/___/_____
Signature of patient or responsible party Date

If this release pertains to alcohol or drug abuse information, please note that: this information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42 C.F.R., Part 2) prohibits you from making further disclosures of it without specific written consent of the patient to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical and other information is NOT sufficient for this purpose.

This message is intended only for the individual or establishment to whom it is addressed. It may contain information that may be confidential under law. If you are not the intended recipient or agent responsible for this message, do not read, print, forward, copy, or distribute this information. If you have received this message in error, or if this document is illegible or incomplete, please contact the sender at sleepdoc@sleepdoc.com or by calling 301-654-1575.