OHIO SLEEP MEDICINE INSTITUTE

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I hereby authorize:

_____

_____

_____

_____

to release to:

Markus H. Schmidt, M.D., Ph.D.
Asim Roy, M.D.
Ohio Sleep Medicine Institute

the following information (list specific reports, types of information):

_____

_____

_____

Signed: _____ **Date:** _____

Parent/Guardian: _____ **Relationship:** _____

Witness: _____ **Date:** _____