



**AUTHORIZATION for RELEASE of MEDICAL RECORDS**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**DAYTIME PHONE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

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

To release to: \_\_\_\_\_  
   \_\_\_\_\_  
   \_\_\_\_\_

\_\_\_\_\_ All 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 taken based on response to this authorization.

\_\_\_\_\_  
Signature of patient or responsible person

\_\_\_\_\_  
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 the 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 records 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 delivering 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 unreadable or not received in full, please contact the sender at [sleepdoc@sleepdoc.com](mailto:sleepdoc@sleepdoc.com) or call (301)654-1575.