Dayton Lung and Sleep Medicine, Inc.

Protected Health Information Release

Please fill out who your confidential information can be disclosed to. Please initial if you would like health information and/or billing information to be released. This includes your spouse, family, friends, etc.

I give my permission to release confidential health and/or billing information to the following people:

Name	Relationship to Patient	For Verification purposes, DOB	Initial for Health information to be Released	Initial for Billing information to be Released
Example: John Doe	Husband	6/20/65	SMD	SMD
1.				
2.				
3.				
4.				
5.				

_____ _____

Signature Date

_____ _____

Print Name Birthdate

_____