PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

HIPAA Waiver

(Patient consent to Release Protected Health Information)

I, _____ hereby authorize PEAK Neurology and Sleep Medicine, LLC to release my medical information to:

_____

This release expires one year after the date of signing (or on: _____) I also understand that I have the right to revoke this release at any time.

Please initial next to each selection that applies:

_____ Billing
_____ Medical Record
_____ Verbal Information
_____ Entire Chart
_____ Other

_____
Patient date of birth

_____
Date

_____
Patient signature

_____
Witness signature