

OMAR TURK, MD

Neurologist- Board Certified



NEUROSLEEP CENTER

DESIGNATE FORM

I give **Neurosleep Center** authorization to release information regarding my health to the following people:

(ie, spouse, brother, sister, other physicians besides referring, etc...)

Please note that anyone not listed on this form, including relatives or immediate family members, will not have access to your file.

This does not authorize the below mentioned to make or change appointments on behalf of patient.

Name: _____ Relation: _____

I give **Neurosleep Center** authorization to release my non-controlled prescriptions to the following person(s).

Please note: persons listed her will only be allowed to pick up prescriptions on your behalf.

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient's Signature: _____ Date: _____

