OMAR TURK, MD

Neurologist- Board Certified

NEUROSLEEP CENTER

AUTHORIZATION TO RELEASE INFORMATION

The Neurosleep Center may disclose all or part of this patient's record to any insurance company, association or the federal or State Government as it may be necessary for the completion of all **Neurosleep Center** claims.

I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug of alcohol abuse. A copy shall be valid as the original.

ASSIGNMENTS OF BENEFITS

I hereby authorize payment to **Neurosleep Center** benefits specified and otherwise payable to me for any services rendered by the clinic in subsequent to this date and for such other charges that may be made by said clinic. I hereby agree to pay the same and also agree that in the event payment by a third party for any individual visit exceeds that necessary to cover charges incurred during that visit, any coverage may be applied to outstanding charges owed that clinic for other services rendered to myself, my spouse, or legal dependents of myself or spouse at that time.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this related medical claim, I request that payment of Authorized Benefits be made on or in my behalf to **Neurosleep Center**.

I, the undersigned, certify that I have read the foregoing, and am that patient or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient's Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

Witness: _____

4190 24th Ave, Ste 210, Fort Gratiot, MI 48059 Tel: 810-216-1901 Fax: (810) 216-1701