SLEEP & LUNGS
Naga Chigurupati, MD

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Authorization to Schedule Testing / Office Visits / Medical Information and Results of Progress or Prognosis

Patient Name_____ Date of Birth_____

I authorize Sleep & Lungs, LLC to talk to the following people regarding my scheduling, office visits, medical information and results if I am unavailable.

o No one other than myself

o My Spouse (name of spouse) _____

o My Children (name of children) _____

o Message on my answering machine voicemail at the following number(s) or any other phone number

_____

I understand that this statement will remain in effect until I notify Sleep & Lungs, LLC in writing of any changes.

Patient Signature_____ Date _____