DO SLEEP SOLUTIONS, INC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DO SLEEP SOLUTIONS requests that patients obtain all records relevant to their appointment with the office. This information may be brought with you or faxed to the office prior to your appointment. It is the patient's responsibility to provide these records. FAILURE TO PROVIDE THESE RECORDS MAY NECESSITATE RESCHEDULING THIS APPOINTMENT.

Instructions: Please complete and sign this authorization and forward it to the appropriate facility to obtain records. If you complete the record request we would be happy to fax this for your at your request. Thank you!

TO: _____ _____

_____ _____

_____ _____

REQUESTED RECORDS:
- ◯ All Sleep Studies and office notes prior
- ◯ All pulmonary function tests/spirometry/6 minute walk tests
- ◯ All chest imaging (chest xray, CT chest, ultrasound, etc)
- ◯ All pertinent clinical notes
- ◯ All laboratory studies
- ◯ Other _____

I hereby authorize you to release my medical records. I understand that my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results of psychiatric or psychological conditions.

Released records may be sent to **DO SLEEP SOLUTIONS, INC**

FAX preferred **10707 66th Street N, Suite B, Pinellas Park, FL 33782**

PHONE: 727-826-0933 FAX: 727-350-3487

If there are NO RECORDS, please indicate here: _____

Patient Name: _____ Date: _____

Date of Birth: _____ Previous name(s) if applicable: _____

Patient signature (over age 18) _____

Personal Representative name & signature (if under 18) _____