# PATIENT MEDICAL RECORD RELEASE FORM

This office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign the record release form below so we can retrieve medical records related to sleep disordered breathing.

**TO**: _____

**FROM**: **Ohio Sleep Treatment** - Collin Emerick, DDS and Brandon Canfield, DDS

We would like to request a copy of the following if applicable:

- All baseline PSG's, oximetry studies, and the patient's most recent CPAP titration study
- Any pertinent notes about patient's past medical history

PATIENT NAME: _____DOB_____

We wish to obtain the records in this way:

___ PLEASE FAX TO THE FAX NUMBER LISTED BELOW

___ PLEASE MAIL TO US AT THE ADDRESS LISTED BELOW

___ PICK UP FROM OFFICE

**ADDRESS**:
**Ohio Sleep Treatment**
6500 Busch Boulevard Suite 104
Columbus OH 43229
**FAX: (855) 858-4924**

*I request and authorize the above named doctor or health care provider, or individual named in this request to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.*

Patient Signature: _____ Date: _____

Additional Comments:

_____

_____

Thank you in advance.