



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, Sandra Pasquinelli, 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

450 Alkyre Run Dr

STE 300

Westerville, OH 43082

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.