Ohio Sleep Treatment
450 Alkyre Run Dr STE 300 Westerville, OH 43082
Phone: (614) 396-8286 Fax: (855) 858-4924

Patient Medical Records Release Form

Patient Name: _____Date of Birth ____/____/_____

I authorize the release of my relevant medical records to Ohio Sleep Treatment from the healthcare provider(s) listed below.

Please list all providers so we can expedite collecting records on your behalf.

Primary Care Provider
Provider/ Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Sleep Medicine Provider
Provider/ Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Pulmonary Provider
Provider/ Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Ohio Sleep Treatment
450 Alkyre Run Dr STE 300 Westerville, OH 43082
Phone: (614) 396-8286 Fax: (855) 858-4924

Dentist

Provider/ Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Other

Provider/ Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Scope of Records to be Released:

☐ All records

Purpose of Release:

☐ Referral ☐ Continuity of care ☐ Second opinion ☐ Personal use

☐ Other: _____

Acknowledgment & Authorization

I understand that my medical records may include sensitive information relating to mental health, HIV/AIDS, substance abuse, or other conditions, and that this information will be included unless I specify otherwise. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken based on it.

This authorization will expire one year from the date signed unless otherwise specified.

Patient Signature: _____ Date: _____

Printed Name of Patient/Legal Representative: _____

Relationship to Patient (if applicable): _____