

Ohio Sleep Treatment

450 Alkyre Run Dr STE 300 Westerville, OH 43082

Phone: (614) 396-8286 Fax: (855) 858-4924

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 as many providers as possible, as the records we need are sometimes spread out across multiple medical specialties.

Primary Care Provider: _____

Office name: _____

Address: _____

Phone: _____ Fax: _____

Sleep Medicine Provider: _____

Office name: _____

Address: _____

Phone: _____ Fax: _____

Pulmonary Specialist Provider: _____

Office name: _____

Address: _____

Phone: _____ Fax: _____

Dentist: _____

Office name: _____

Address: _____

Phone: _____ Fax: _____

Other Specialist (i.e. ENT): _____

Office name: _____

Address: _____

Phone: _____ Fax: _____

Records to be released:

All sleep-related records, including (but not limited to) clinical notes related to the ordering of sleep testing, sleep studies, sleep study results communications, clinical notes with treatment recommendations, and documentation of sleep apnea comorbidities.

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/Legal Representative Signature:

Today's date: _____

Printed name of Patient/Legal Representative: _____

Relationship to Patient (if applicable): _____