



MEDICAL RECORDS RELEASE
Release to Sleep HealthCenters

TOLL FREE FAX: 866-799-0601
 PHONE: 877-SLEEPHC or 877-753-3742
 info@sleephealth.com – www.sleephealth.com

The patient named below has requested we receive a copy of their medical records.
Processing this request requires an up-front fee payment of \$50 payable to Sleep HealthCenters.
 (The fee will be waived if you show that your request is to support a claim or appeal under any provisions of the Social Security Act in any federal or state financial needs-based benefit program.)

(Please fill this form out in black pen.)

LAST NAME _____ FIRST NAME _____ DATE _____

HOME ADDRESS _____

PHONE # _____ ALT PHONE # _____ DOB _____

PATIENT REQUEST

<u>Document Type</u>	<u>Date(s)</u>	<u>Notes</u>
<input type="checkbox"/> History	_____	_____
<input type="checkbox"/> Physical	_____	_____
<input type="checkbox"/> Clinic Notes	_____	_____
<input type="checkbox"/> _____ <i>(please specify)</i>	_____	_____
<input type="checkbox"/> _____ <i>(please specify)</i>	_____	_____
<input type="checkbox"/> _____ <i>(please specify)</i>	_____	_____

PLEASE SEND A COPY OF MY RECORDS DIRECTLY TO THE PERSON(S) LISTED BELOW:

Requesting Records From:

NAME _____
 ADDRESS _____
 PHONE NO _____
 FAX NO _____

Send Records To:

NAME Sleep HealthCenters
 ADDRESS 187 Ballardvale Street, Suite 202
Wilmington, MA 01887
 PHONE NO 877-753-3742
 FAX NO 866-799-0601

AUTHORIZATION

This request is good for 1 year from the below signature date.

Patient or Legal Guardian Name: _____ Date: _____
Please Print

Signature: _____
Information will not be released without a valid signature.