bay sleep clinic

☐ Request for Medical Information
☐ Release of Medical Information

**Authorization:** I hereby authorize: ______________________________
name of physician, hospital, clinic etc.

______________________________
address of above agency

______________________________

to release any and all record or a summary of findings and recommendations as listed below. I understand that this information may be communicated verbally, in writing, via audio or video means, or other means as deemed necessary and appropriate.

______________________________

______________________________

Please send for review the following: X-rays, pathology slides, EKG's, etc.
These will be returned as soon as possible.

______________________________

______________________________

**Please send information to:** ______________________________

______________________________

______________________________

**Regarding:**

Patient's Name: ______________________________

Our Record Number: ______________________________

Address: ______________________________

______________________________

Birth Date: ______________________________

Former Name: ______________________________

Other Record or Identifier: ______________________________

Approximate Date of Care: ______________________________

**Duration:** This authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing.

**Restrictions:** I understand that this information cannot be further released without my specific written consent. No further authorization is made than is specifically indicated herein.

**Additional Copy:** I further understand that I have a right to receive a copy of this authorization upon my request.

______________________________
Witness

______________________________
Patient, parent, guardian, or legal representative signature

______________________________
Date