

RECORDS RELEASE

Name: _____

D.O.B: _____

Date: _____

I hereby authorize use or disclosure of protected health information about me as described below for the purpose of continuity of care:

____ Past Sleep Studies

____ X-ray

____ CT Scans

____ Office Notes

____ Labs

____ Other:

Facility/Physician Name: _____

I understand this authorization may be revoked by me at any time except to the extent the information has already released.

Signature