Commonwealth Sleep Center

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CONTACT US | **www.commonwealthsleepcenter.com**

MEDICAL RELEASE FORM

PATIENT INFORMATION

TODAY DATE: ___/____/____

First Name: ______________________________Last Name ____Middle_________

Date of Birth: ___/____/_____ Age: __________________ Social Security: #_____/____/_______

Home Address: _________________________________ APT# _____________________________________

City: _____________________ State: __________Zip: ____________________

Home Phone #: ________-______-_____ Work Phone #: _______-________-_____ EXT_________

Mobile Phone #: _____-________-______ Email Address: ___________________________________

Please check the information you are requesting

☐ Office Visit Notes ☐ Sleep Study Reports ☐ All Records

I____, do hereby authorize Commonwealth Sleep Center to release or get
(Patient's Name)

PLEASE CHECK ANY ONE OF THE OPTION: ☐ RELEASE **OR** ☐ GET RECORDS FROM

____
Name of company / agency / facility / person

____
Street address

____
City, state, zip code

____
Phone number Fax number

Purpose of disclosure:

I hereby authorize disclosure of the health information above. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information release prior to notification of cancellation, I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it and would then no longer be protected by federal regulations.

____
Signature of Patient/Guardian/Legal Representative

****** Note: There will be a charge for personal copy and permanent transfer of your records *****