



REQUEST FOR RELEASE OF MEDICAL INFORMATION

I DECLINE. I DO NOT HAVE ANY MEDICAL RECORDS TO BE SENT TO SLEEP INSIGHTS.

Please release a copy of my medical record to:

Name of Doctor, Medical Practice or Individual:

Jacob Dominik, MD, PLLC, Sleep Insights

Mailing Address of Requested Recipient:

755 Jefferson Road, Suite 110, Rochester, NY 14623

Phone Number of Recipient:

585-385-6070

Facsimile Number (Fax) of Recipient:

585-385-6071

Patient Signature (or signature of legal guardian):

Printed Name of Patient:

Date of Birth:

PLEASE NOTE THE FOLLOWING:

You can always obtain a copy of your personal medical information for your own records. Once your medical records are in your possession you may copy them and deliver them according to your preferences. Your confidential medical information will only be sent to the place you have indicated on this form; please ensure that the address and/or fax number is accurate. Please allow us ten days to process a routine request. If more urgency is needed, we will attempt to expedite your request.