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 records to:

Name of Doctor, Medical Practice or Individual:
Sleep Insights Medical Associates PLLC

_____

Mailing Address of Requested Recipient:

_____

Phone Number of Recipient:

_____

Facsimile Number (Fax) of Recipient:

_____

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.