(704) 266-0808
10230 Berkeley Pl Dr # 200,
Charlotte, NC 28262

Monday-Friday 9:00am-5:00pm

Authorization to Transfer Medical Records

Authorization

I hereby authorize _____ to release any and all medical records, including but not limited to hospitalization for diagnosis and/or treatment of obstructive sleep apnea. Please include any and all records including all diagnostic and titration sleep studies, office notes, and surgical treatments.

Release to: Practice: _____

Release from: Doctor: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____

Uses

The purpose of the release of this information is:
Continuity of Medical Care ☐
Other (Specify) _____ ☐

Restrictions

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or discloser is specifically required or permitted by law.

Duration

This authorization will expire 60 days from today or at an earlier date, at my election (To cancel this authorization prior to the above limit, notification must be sent to the Medical Record Department in writing and bear the patient's or legal representative's signature.

Patient Information *(Please print)*

Patient's Name: _____
Date of Birth: _____ Social Security #: _____
Date(s) of Treatment: _____

Signatures

Patient's Name: _____ Date: _____
Legal Representative's Signature: _____ Date: _____

Submit