PATIENT MEDICAL RECORD RELEASE FORM

This office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign the record release form below so we can retrieve medical records related to sleep disordered breathing.

To: _____

From: Dr. Rebecca Lauck

We would like to request a copy of the following if applicable:

- All baseline PSG's, oximetry studies, and the patient's most recent CPAP titration study
- Any pertinent notes about patient's past medical history

Patient Name: _____

Patient DOB: _____

We wish to obtain them in this way:

☐ PICK UP FROM OFFICE

☐ PLEASE MAIL TO US AT THE ADDRESS LISTED BELOW

☐ PLEASE FAX TO THE PHONE NUMBER LISTED BELOW

ADDRESS:

1675 Keller Parkway Suite 100
Keller TX 76248

FAX: (888) 975-1974

I request and authorize the above named doctor or health care provider, or individual named in this request to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Patient Signature: _____ **Date:** _____

Additional Comments:

_____

_____

_____

Thank you in advance.