Mountain
Sleep Diagnostics
Phone: (303) 396-5923 Fax: (303) 957-5414

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ **Date of Birth:**_____

The information you may release subject to this signed release for is as follows:

- □ History&Physical
- □ Care Plan
- □ Lab Reports
- □ Pathology reports
- □ Treatment Record
- □ Medication List
- □ Progress Notes
- □ Radiology Reports
- □ Operative Reports
- □ Complete Record
- □ Hospital reports
- □ Other _____

Release my protected health information to the following physician/person/facility/entity/ and or those directly associated in my medical care:

Name:_____

Address:_____

City, State, Zip**:**_____

The purpose/reason for this release of information is as follows:

_____

_____

_____