Midwest Sleep Diagnostics
13975 Manchester Road, Suite #9
Manchester, MO 63011-4500
(636) 227-8787 Fax (636) 227-8610

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RECORDS TO BE TRANSFERRED TO Midwest Sleep Diagnostics:

I, the undersigned, hereby request and authorize:

(Name of physician or institution) (Telephone #) (Fax #)

(Street address) (City) (State) (Zip)

to release all information below to:

Midwest Sleep Diagnostics
13975 Manchester Road, Suite 9
Manchester, MO 63011

Phone # (636) 227-8787
Fax # (636) 227-8610
E-mail records@midwestsleep.com

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INFORMATION REQUESTED

- ☐ **All Records** _____
- ☒ **All Records Concerning** **SLEEP STUDIES**
- ☐ **Specific Treatment Date(s) of** _____
- ☐ **Other (Specify)** _____

For the purpose of : Providing Further Care

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I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

(Signature of patient of legal guardian)

(Printed Name) (Date of Birth)

(Date) (Address)