



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize United Sleep Medicine and/or its agents:

(Check one)

_____ To release information regarding my medical care and/or treatment to:

Or

_____ To request information regarding my medical care and/or treatment from:

I understand that I may revoke this consent at any time, except to the extent that action has already been taken.

Patient Signature (parent, guardian, caretaker) **Date**
[if other than patient signature, relationship: _____]

Witness Signature **Date**

MAIL FORM:

Medical Records
United Sleep Medicine
5821 Fairview Road, Suite 409
Charlotte, NC 28209

FAX FORM: 704-377-9992, Attention: Medical Records