PATIENT MEDICAL RELEASE FORM

p. 906.242.2443
f. 833.249.5211

Levata SLEEP

Our 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: Levata Sleep

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:** _____

Please provide records via fax, mail, or e-mail.

Levata Sleep
304 State Hwy 553
Marquette, MI 49855

fax 833.249.5211
info@levatasleep.com

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: _____

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Thank you!