The Doctor requests that patients obtain all records relevant to their appointment with the office. This information may be brought with you or faxed to the office prior to your appointment. It is the patient's responsibility to provide these records. FAILURE TO PROVIDE THESE RECORDS MAY NECESSITATE RE-SCHEDULING THIS APPOINTMENT.

INSTRUCTIONS: Please complete and sign this authorization and forward it to the appropriate facility to obtain records.

THANK YOU!!!

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

RECORDS REQUESTED:
- ◯ All Sleep Studies
- ◯ All PFT/SPIROMETRY/6MW
- ◯ All IMAGING (Chest X-Ray/CT, ultrasound, ETC)
- ◯ All office notes prior to procedures
- ◯ Other _____

I hereby authorize to you to release my medical records. I understand that my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results of psychiatric or psychological conditions.

Released records may be sent to **DO SLEEP SOLUTIONS, INC/Michelle Zetoony, DO**

10707 66th Street N, Suite B **OR** 1831 N. Belcher Rd, Ste E-1

Pinellas Park, FL 33782 Clearwater, FL 33765

****FAXED RECORDS PREFERRED**** PHONE: 727-826-0933 **FAX: 727-826-0933**

If there are no RECORDS, please indicated here: _____

Patient name: _____ Date: _____

Date of birth: _____ Previous Name if applicable _____

Patient Signature (over age 18) _____

Personal Representative name & signature _____