Sierra Pulmonary &
Sleep Institute
"Comprehensive Compassionate Care"

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:_________________________________ D.O.B _______________
(Print)

____
Address City State Zipcode

Phone #:____

I Hereby Request that my medical records be released to:

Self (Patient)_______

I permit this confidential Information to be released for the following purpose:

Coordination of care_______ Own records_______

RECORDS TO BE RELEASED:

______Testing ______Sleep Studies ______ Recent Notes _____ Compliance Report

________________________________ ________________________________
Signature of Patient/Parent or Guardian Date

This authorization will expire twelve months after the date above.

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info@sierrapulm.com

****SUBJECT TO A .60 PER PAGE CHARGE FOR MEDICAL RECORDS + POSTAGE AFTER NOVEMBER 16TH 2017****