Sierra Pulmonary & Sleep Institute

"Comprehensive Compassionate Care"

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ D.O.B_____
(Print)

_____
Address City State Zip code

Phone #:_____Email:_____

I Hereby Request that my medical records be released to:

Self (Patient)_____

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

Own records_____

_____ _____
Signature of Patient Date

This authorization will expire twelve months after the date above.

New Address:
PO Box 50254, Sparks, NV 89435
info@sierrapulm.com

****SUBJECT TO A .60 PER PAGE + POSTAGE CHARGE****