SLEEP & CARDIO VASCULAR HEALTH

Michael Ledet, MD
Diplomate
American Board of Sleep Medicine & Clinical Lipidology

Sara Welch, MHSc, PA-C
Diplomate, Clinical Lipidology
Certified Obesity Management

Name _____ Date of Birth _____

Address _____ Phone Number _____

City, State, Zip Code _____ Social Security Number _____

I hereby authorize _____to release the following information to
Name of Hospital/Healthcare Facility

Sleep & Cardiovascular Health Fax 251-278-3930
Facility Name

- ☐ Office Notes
- ☐ Lab Results
- ☐ Diagnostic Test Results
- ☐ Radiology Reports
- ☐ Complete Sleep Studies
- ☐ Consultations
- ☐ Discharge Summary
- ☐ ER Record
- ☐ Entire Record
- ☐ Other_____

Dates of Hospitalization or visit _____

This consent and authorization may include, but is not limited to, the release of medical, alcohol and/or drug abuse treatment, psychological, psychiatric, sexually transmitted diseases, and HIV.AIDS information.

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing and presented to the Medical Records Department. This authorization will expire (i) after 6 months, (ii) after disclosure is made, (iii) the date specified here: _____, to accomplish the purpose of the disclosure stated above.

_____
Signature of Patient/Representative Date Relationship if other than &/or Authority to act for the patient

_____
Witness

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45, CFR. Sleep & Cardiovascular Health may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

REQUEST FOR RELEASE OF MEDICAL INFORMATION