Mountain
Sleep Diagnostics
A PROFESSIONAL SLEEP SERVICES COMPANY

Medical Records Release

Authorization for Request/Release of Medical Records

This authorization is necessary for us to comply with state and federal laws pertaining to the request and or release of medical records regarding the patient identified below. Please provide all of the requested information. Failure to provide all requested information may prevent Mountain Sleep Diagnostics from acting on this authorization.

Patient Name _____Date of Request ____/____/_____

Address _____

Date of Birth _____/_____/_____

Persons Authorized to Release		Request Medical Records Sent To	
Name	_____	Name	_____
Address	_____	Address	_____
City, State, Zip	_____	City, State, Zip	_____
Phone/Fax	_____	Phone/Fax	_____

Description of Information

_☐_All Medical Records _☐_ Clinic Notes _☐_ Sleep Studies

This authorization does expire one year after it has been signed, or at the written request of the patient. There is a copy fee associated with a medical records request. To copy medical records a service fee of $15 for records of 10 pages or more. If this a STAT request, there is a $20 STAT fee in addition to copy fees, payable at the time of the request.

_____Date ____/____/_____
Signature

Please complete this form in its entirety and fax this form and a copy of your Driver's License to Mountain Sleep Diagnostics, Inc at 303.957.5415