Patient Medical Record Release Form

This office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign the record release form below so we can retrieve medical records related to sleep disordered breathing.

For Patient: ____DOB:___________

Patient Phone #: ____

Requesting Records to/from Dr's. Office:

Doctor: __________________________________ Phone #: __________________

Fax #:_________________ Email: ______________________________________

We are requesting a copy of the patient's sleep study and pertinent notes about the patient's past medical history. Please fax or email these records to the following.

Fax: 940-498-2366
Email: info@dfwsleeps.com

I, ___________________________, hereby request that my medical records be released to/from

DFW Sleep Solutions office of Dr. Suzanne Thai
3941 FM 2181
Corinth, TX 76210

Patient Signature: ____

Today's Date: _______________