Release of Information

Patient Name:_____

Previous name used : _____

Date of Birth _____

I hereby Authorize: (Please circle your practice)

Inspire Health	Willow Women's Health	Sleep Medicine Of DFW
469-200-6100	469-476-5623	(469) 361-2784
Fax: 469-200-6101	Fax: 469-476-5624	Fax: (469) 200-6101

INSPIRE HEALTH

WILLOW WOMEN'S HEALTH

Sleep Medicine of DFW

To obtain Medical Records from:

Physician or Business name : _____

Address:_____

Phone Number _____ Fax:_____

To release Medical records to:

Physician or Business name : _____

Address:_____

Phone Number _____ Fax:_____

Information to be requested or released for the purposes of:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Medication Record
- ☐ Treatment Record
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ Other (please specify)_____

Patient Signature_____

Date:_____Printed Name_____