3100 Duraleigh Road
Suite 302
Raleigh, North Carolina 27612
(919) 645-9280/Fax No. (919)208-2149

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL TREATMENT INFORMATION

This form is submitted on behalf of our mutual patient:

____

Patient Name **DOB** **Social Security#**

The patient referenced above has agreed to inquire and request the prompt release of his/her medical information indicated below:

☐ **Medical Diagnostic** ☐ **Medical Treatment**

☐ **Laboratory & X-ray Results** ☐ **Prescription medication history**

☐ **All Sleep Study Records** ☐ **Most Recent Sleep Study**

When (date/year) was the study performed? __________________

Where (name/address of facility) was the study performed?

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Who ordered the Sleep Study?___________________________

☐ **Accident Related Information** ☐ **Work Comp** ☐ **MVA**

Date of Accident: _______________________________________

Insurance Carrier Information:

____

If Work Comp, name & number of supervisor approving treatment.

____

Supervisor Name **Phone**

You may **fax information** to the following number: **919-208-2149**

My signature below signifies my request and hereby indicates my authorization for my doctor to receive my records from and or provide Wake Sleep, LLC with my medical treatment information.

Date______________ **Signature**____