# Release of Medical Records Authorization

**Patient Information**

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

**Company Authorized to Release My Medical/Billing Records**

Name of my current/former equipment supplier: _____

Phone number of current/former equipment supplier: _____

**Instructions Regarding Release of Medical Records**

Please release my medical/billing records to Fayette Medical Supply, Inc. as follows:

Fax: _____ Telephone: _____

Mailing Address: _____

Please send medical records no later than: _____

Please send the following records (e.g., sleep study, prescription, etc.):

**OXYGEN:** OFFICE VISIT F2F, O2 SAT TESTING LISTED ON 484, INITIAL & RECERT 484 CMN FORM(S), AND OXYGEN DELIVERY TICKET POD

**CPAP/BI-LEVEL:** OFFICE VISIT F2F B4 PSG, ALL PSG REPORTS, INITIAL CMN, INITIAL DELIVERY TICKET OF EQUIPMENT, LAST 6 MONTHS OF SUPPLY RECORDS

OR OTHER RECORDS AS LISTED:

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By my signature, I authorize the release of pertinent medical and/or billing information in accordance with the instructions above.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Printed Name Relationship to Patient