Sleep Life Med 91-3575 Kauluakoko St. #1601, Ewa Beach, HI 96706 Phone: (808) 500-7077 I Fax: (808) 460-3840

sleeplifemed

SLEEP WELL, LIVE BEST

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

DATE:

PATIENT NAME:

BIRTHDATE:

PHONE:

EMAIL:

LAST 4 SSN:

Requested Information:

____ H&P

____ Progress notes from the past 12 months

____ Sleep studies and CPAP compliance reports

____ Cardiac studies: EKG, echocardiograms, stress tests, Holter monitoring, zio patch reports

____ Consultation records from the previous 2 years

____ Laboratory results from the previous 12 months

I, _____ hereby authorize and request the disclosure of all protected health information requested above to be sent to Dr. Valerie Cacho for continuity of care.

I understand that I may be charged a reasonable fee for photocopying and/or transmittal of these records.

This authorization request will expire 1 year from the date signed and may be withdrawn at any future time.

_____ _____

Patient's Signature, Authorized Representative or Legal Guardian if <18yr

Date

Please send requested information to the address, fax or email listed on this form