SLEEP THERAPY SOLUTIONS

1340 Corporate Dr Suite 200
Hudson, Ohio 44236
Phone: (330) 655-0630 / (866) 858-9480 Fax: (330) 655-0632

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: SLEEP THERAPY SOLUTIONS

Address: 1340 CORPORATE DRIVE, SUITE 200

City: HUDSON State: OH Zip Code: 44236

Fax: 330-655-0632

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All Applicable testing (oximetry, sleep studies): _____

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.