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: **(979) 859-7184** Telephone: **800-442-6704**

Mailing Address: **PO Box 939, La Grange, TX 78945**

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), OXYGEN DELIVERY TICKET POD, AND BILLING RECORDS

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

OR OTHER RECORDS AS LISTED: ☐

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