SLEEP NEEDS OF ROUND ROCK

Dan R. Baker, M.D.

16010 Park Valley Dr. Ste 200

Round Rock, TX 78681

P: 512-496-0394, F: 512-843-4480

**Authorization for Release of Medical Information**

*Please note there may be a charge for providing copies of your medical records as allowed by Federal & State Law*

|  |  |
| --- | --- |
| I authorize Dan R. Baker, M.D. to OBTAIN information from:Name of Provider or Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE# & FAX#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | I authorize Dan R. Baker, M.D. to RELEASE information to:Name of Provider or Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE# & FAX# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Dan R. Baker, M.D. liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Legal Representative Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship of Patient (if Legal Representative) Witness |
| TYPE OF RECORDS REQUESTED:* Progress notes
* Sleep Study results
* Treatment Information
* Referral Inormation

Specific records as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**By signing this document, you are approving Sleep Needs Of Round Rock to obtain & release your**

**medical records as outlined above.**

Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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