MEDICAL RECORDS RELEASE
Good Night Medical, Inc. Records

Please fax, scan or mail the completed form to:

MAIL: Good Night Medical Records Department
975 Eastwind Dr, Suite 165, Westerville, OH 43081
FAX: 844-326-3118
PHONE: 877-753-3742
Email: info@goodnightmedical.com
www.goodnightmedical.com

LAST NAME _____ TODAY'S DATE _____

FIRST NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

Document Type

____Sleep Study Reports ____Prescription ____PAP Therapy Please Specify: _____

Date(s):_____ Notes:_____

___Mail to Patient/Physician ___Fax to Physician ___Send electronically to Physician with proper file security

REQUESTING RECORDS FROM:

NAME Good Night Medical

ADDRESS 975 Eastwind Dr., Suite 165

Westerville, OH 43081

PHONE 877-753-3742

FAX 844-326-3118

SEND RECORDS TO:

NAME _____

ADDRESS _____

_____

PHONE _____

FAX _____

PAYMENT INFO: $20 Medical Records and 50 cents per page beyond 10 pages * See Note below

Credit Card #_____ Exp Date:_____ 3 or 4 Security #_____

Name on Card:_____

Billing Address:_____

City:_____ State: _____ Zip Code:_____ Telephone #_____

This request is good for 1 year from the below signature date.

Patient or Legal Guardian Name (Please Print):

_____Date:_____

Signature:_____

Information will not be released without a valid signature.

Note: No charge for current customers of Good Night Medical owned companies or with a currently referring physician. There is also no charge to certain DME providers who are part of our network of Sleep Providers (ask us)