MEDICAL RECORDS RELEASE
Release to Good Night Medical

TOLL FREE FAX: 844-326-3118
PHONE: 877-753-3742
info@goodnightmedical.com
www.goodnightmedical.com

The patient named below has requested we receive a copy of their medical records.

PATIENT INFORMATION

LAST NAME _____ TODAY'S DATE _____

FIRST NAME _____ DATE OF BIRTH _____

ADDRESS _____

_____

PHONE _____

PATIENT REQUEST

Document Type	Date(s)	Notes
☐ History		
☐ Physical		
☐ Cinical Notes		
☐		
☐		

PLEASE SEND A COPY OF MY RECORDS DIRECTLY TO THE PERSON(S) LISTED BELOW:

REQUESTING RECORDS FROM:

NAME_____

ADDRESS _____

_____

PHONE_____

FAX _____

SEND RECORDS TO:

NAME Good Night Medical

ADDRESS 975 Eastwind Dr, Suite 165,
Westerville, OH 43081

PHONE 877-753-3742

FAX 844-326-3118

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

Patient or Legal
Guardian Name: _____ Date: _____
Please print

Signature: _____
Information will not be released without a valid signature.