



Authorization for Release of Medical Records

Patient Information

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Party Authorized to Release My Medical/Billing Records

Name of my current/former equipment supplier: _____

Instructions Regarding Release of Medical Records

Please release my medical/billing records to Apria Healthcare as follows:

Fax: _____ Telephone: _____

Mailing Address: _____

Please send medical records no later than: _____

Please send the following records (e.g., sleep study, prescription, etc.): _____

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