Apria Healthcare®

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.

Patient Signature: ______________________________ Date: ______________

©2013 Apria Healthcare Group Inc.