Blanchard Valley Sleep Disorders Center
419.427.2604 • Fax 419.427.2607 • 1909 South Main Street • Findlay, Ohio 45840

RELEASE OF PATIENT INFORMATION

List all of your current doctors with whom we should share your information to coordinate your medical care.

Primary Care Physician _____

Address _____

Phone (_____) _____-_____

Fax (_____) _____-_____

Physician _____

Address _____

Phone (_____) _____-_____

Fax (_____) _____-_____

I authorize Blanchard Valley Sleep Disorders Center to leave a message pertaining to my care (i.e. what department we are calling from, reminder for appointments, etc), by the following methods. I will assume responsibility to notify them if this information changes.

Home Telephone/Voicemail/Answering Machine *(_____)* _____ - _____ _____ *yes* _____ *no*

Work Telephone/Voicemail/Answering Machine *(_____)* _____ - _____ _____ *yes* _____ *no*

Cell Phone/Voicemail *(_____)* _____ - _____ _____ *yes* _____ *no*

Please list the names of any people you authorize to receive messages or information regarding your personal medical information.

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

X_____ _____
Patient Signature Date

THIS SPACE FOROFFICE USE ONLY

PSG	**Cert#**	**HST**	**Cert#**
CPAP	**Cert#**	**ROV**	**Cert#**
TV	**Cert#**	**ROV**	**Cert#**