The Doctor requests that patients obtain **all records** relevant to their appointment with her. This information may be brought with you or faxed to the office prior to your appointment. **It is the patient's responsibility to provide these records.** Failure to provide these records may necessitate re-scheduling the appointment.

INSTRUCTIONS: Please complete and sign this authorization and forward it to the appropriate facility to obtain records.

Thank you!

Lisa A. Whims-Squires, D.O., P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: ……..
……..
……..
……..

Record Requested: All Sleep Study interpretation and raw data (computer Generated graphs and figures)
Other: ……..
……..
……..

I hereby authorize to you to release my medical records. I understand my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results and psychiatric or psychological conditions.

Release Record To: Lisa A. Whims-Squires, D.O.
1305 S. Fort Harrison Avenue, Building G
Clearwater, FL 33756
Phone: 727-466-9847 Fax: 727-466-0346

Other: ……..
……..
……..

Patient name (PRINT): _____ Date: _____

Social Security #: _____ Date of birth: _____

PATIENT SIGNATURE (over age 18): _____

PERSONAL REPRESENTATIVE NAME & SIGNATURE: _____