Lung, Allergy & Sleep
MEDICINE CENTER

REQUEST FOR MEDICAL RECORDS

Date ____________________

Requesting Records From: _______________________________________

Location: ____

Patient's Name: ____

Patient's Date of Birth: ____

Patient's authorization to release of medical records:

Patient's signature: ____

DOCUMENTS REQUESTED

_____Admission history and physical examination

_____Consultation reports

_____X-ray reports

_____CT Chest reports

_____ Polysomnogram reports

_____Pulmonary Function Tests

_____Discharge summery

_____Other: ____

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