AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

SUPERIOR SLEEP AND WELLNESS LLC COORDINATES TREATMENT WITH YOUR HEALTHCARE PROVIDERS TO HELP ENSURE MAXIMUM BENEFIT TO YOU. PLEASE SIGN THE RECORD RELEASE FORM BELOW SO WE CAN RETRIEVE RELATED MEDICAL RECORDS.

Patient's Name: _____

Date of Birth: _____

I request and authorize _____

To release healthcare information of the patient named above to:

Office: Superior Sleep and Wellness LLC

Address: 2510 South Rochester Road Suite B

City: Rochester Hills State: MI Zip: 48307

Phone: 248-844-1415 Fax: 248-844-1864

Email: superiorsleepandwellness@gmail.com

- All healthcare information in regard to said patient for the past year, i.e. office notes.
- Any and all pertinent notes about patient's past medical history.

Please fax to the number listed above.

_____

Patient/Guardian Signature Printed Date

This authorization expires ninety (90) days after it is signed