PULMONARY SLEEP &
CRITICAL CARE SPECIALISTS

Carlos E. Maas, MD, FACP, FCCP, FAASM
Fabrizio Monge, MD, FCCP, D, ABSM
Lohaliz Bobe, MD, FCCP
Edgardo Soto, MD, FCCP

ONLY COMPLETE THIS FORM IF YOU ARE CURRENTLY USING OR HAVE USED A PAP MACHINE IN THE PAST:

Physician Name that ordered your sleep study: _____

Address or City & State: _____ **Phone:** _____

Approximate date of study: _____

Sleep study done at: _____ **Location:** _____

Medical Equipment Provider: _____ **Location:** _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and request you to release to: Carlos E. Maas, MD, Fabrizio Monge, MD, Lohaliz Bobe, MD, and/or Edgardo Soto, MD aka Pulmonary Sleep and Critical Care Specialists.

Pulmonary Sleep & Critical Care Specialists

Phone: 941-613-1777 Fax: 941-613-1779

The following information:

☒ **Office Visits (Prior to sleep study, listing symptoms and need for study)**

☒ **Sleep Studies**

☒ **Initial Compliance Records and/or Notes**

From the Medical Record of: _____ _____

Patient Name **DOB**

_____ XXX-XX-_____

Address **Social Security Number**

For the purpose of continuing care. Any and all information I hereby authorize to be obtained from this agency/facility will be held in the strictest of confidence and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect until I withdrawal my consent in writing.

_____ _____

Patient Signature Date

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25086 Olympia Avenue, Suite 300, Punta Gorda, FL 33950 • Phone: 941-205-5300 • Fax: 941-205-5302