



**TRANSCEND
MEDICAL**

Going Beyond The Limits

800-403-3740

www.transcendmedical.net

Consent to Release Medical Records

I, _____, authorize the release of my medical records to Transcend Medical, so they will be able to obtain information needed to bill my insurance.

___ Oxygen Saturation/Blood Gas Reports

___ Certificate of Medical Necessity for _____

___ History and Physical

___ Discharge Summary

___ Physician Consults/Summary/Orders/Signed Orders

___ CT Scan and Reading

___ Face Sheet/Progress Notes

___ Sleep Study/Titration/Interpretation/Cpap Follow Up

___ Other _____

Requestor Signature _____

Date _____

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