



DON'T IGNORE THE SNORE

Durable Medical Equipment (DME) Release Form

Patient Information:

- Patient Name: _____
- Date of Birth: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Email Address: _____
- Insurance Provider: _____
- Policy/ID Number: _____

I, _____, hereby authorize the release of my durable medical equipment (DME) records, including sleep equipment records, to Sleeptopia/CPAP and Supplies by Sleeptopia for the purpose of transferring my care and services to their practice. I understand that this release of information includes but is not limited to:

- Prescription and order details for sleep equipment, including CPAP machines, masks, tubing, filters, and humidifier chambers.
- Compliance data related to my use of sleep equipment, such as usage hours and therapy adherence.
- Billing and insurance information related to sleep equipment services and supplies.
- Original Sleep test and script

Please fax requested information to: 888-510-0314

I acknowledge that I have the right to request a copy of this release form for my records.

Patient Signature: _____

Date: _____