MEDICAL RECORDS RELEASE

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____

PHONE: _____ EMAIL: _____

REQUESTED DOCUMENTS

SLEEP STUDY_____ PRESCRIPTION FOR ORAL APPLIANCE _____

PROGRESS NOTES _____ OTHER: _____

COMMENTS: _____

I REQUEST AND AUTHORIZE THAT A COPY OF MY MEDICAL RECORDS BE SENT TO THE FOLLOWING OFFICE:

AZ SLEEP AND SNORING CENTER

6920 E. SHEA BLVD, SUITE 203

SCOTTSDALE, AZ 85254

PHONE: (480) 699-1017

FAX: (480) 634-5560

EMAIL: INFO@AZSLEEPCR.COM

X_____ DATE: _____

SIGNATURE OF PATIENT OR GARDIAN