



MEDICAL RECORDS RELEASE

Please fax the completed request form to 480-830-3901 or mail to:
 Valley Sleep Center Medical Records, P.O. Box 30388 Mesa, AZ 85275-0388
 Email requests may be sent to sleep@valleysleepcenter.com

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

<u>DOCUMENT TYPE</u>	<u>DATE(S)</u>	<u>NOTES</u>
<input type="checkbox"/> SLEEP STUDY RESULTS	_____	_____
<input type="checkbox"/> CONSULT NOTES	_____	_____
<input type="checkbox"/> PAP THERAPY	_____	_____
<input type="checkbox"/> ALL RECORDS	_____	_____

PLEASE SEND A COPY OF MY MEDICAL RECORDS DIRECTLY TO THE FOLLOWING PERSON(S) / ENTITY:

SELF

RELEASE RECORDS FROM:

SEND RECORDS TO:

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ PHONE: _____

FAX: _____ FAX: _____

***I HEREBY AUTHORIZE VALLEY SLEEP CENTER TO DISCLOSE INFORMATION FROM MY MEDICAL RECORDS TO:**

NAME: _____ PHONE: _____

ADDRESS: _____

 PATIENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)

 DATE

 SIGNATURE

 DATE

MESA
 4555 E. INVERNESS
 BLDG. 3
 MESA, AZ 85206

BILTMORE
 4141 N. 32ND ST.
 SUITE 104
 PHOENIX, AZ 85018

ARROWHEAD
 6320 W. UNION HILLS
 BLDG. B, SUITE 1000
 GLENDALE, AZ 85308

CHANDLER
 1120 S. DOBSON RD.
 BLDG. B, SUITE 100
 CHANDLER, AZ 85286

SCOTTSDALE
 9767 N. 91ST ST.
 BLDG. B, SUITE 104
 SCOTTSDALE, AZ 85258