#           

                       

**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:

Requested by Patient:

Document Type:

Sleep Study Results Consult Notes PAP Therapy Prescription

All Records Other, please specify:

Date(s): Notes:

Please send a copy of my medical records directly to the following person(s)/entity below.

Release records from: Send records to:

Name: Address: Phone: Fax:

Name: Address: Phone: Fax:

I hereby authorize Valley Sleep Center to obtain and/or disclose information regarding my medical records unless revoked in writing. This request is good for one year from the signature date below.

Patient/Legal Representative or Parent/Legal Guardian Printed Name Date

Patient/Legal Representative or Parent/Legal Guardian Signature Date