Valley Sleep Center
A Night and Day Difference!

PHONE: (480) 830-3900
FAX: (480) 830-3901
valleysleepcenter.com

ACCREDITED FACILITY MEMBER

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:

Name: _____

Address: _____

Phone: _____

Fax: _____

Send records to:

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**