

**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](mailto: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: \_\_\_\_\_

I authorize Valley Sleep Center to obtain or release my confidential medical records or a summary of my protected health information from the Doctor/Clinic/Persons/Entity below. This request is good for 1 year from the signature date of the request unless revoked in writing.

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

FAX: \_\_\_\_\_

\_\_\_\_\_  
**PATIENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**