To: _____ Date:_____

Fax:_____

From:_____

I _____ authorize any and all medical/dental practices to release my health records to Oral Sleep Medicine of Arizona.

Please fax all of my_____ records to Oral Sleep Medicine of Arizona at **480-376-0462**.

Patient Name_____

Date of Birth_____

Patient Signature_____

Date_____

Thank you and if you have any questions please contact us at 480-503-0967.