



Menlo Park
San Francisco
Los Gatos

Walnut Creek
Berkeley
Fremont

www.baysleep.com

Tel: 1-866-88-SNORE (1-866-887-6673)
Fax: 1-866-44-APNEA (1-866-442-7632)

- Request for Medical Information
- Release of Medical Information

Authorization: I hereby authorize:

name of physician, hospital, clinic etc.

address of above agency

to release any and all record or a summary of findings and recommendations as listed below. I understand that this information may be communicated verbally, in writing, via audio or video means, or other means as deemed necessary and appropriate.

Please send for review the following: X-rays, pathology slides, EKG's, etc.
These will be returned as soon as possible.

Please send information to:

Regarding:

Patient's Name: _____

Our Record Number: _____

Address: _____

Birth Date: _____

Former Name: _____

Other Record or Identifier: _____

Approximate Date of Care: _____

Duration: This authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing.

Restrictions: I understand that this information cannot be further released without my specific written consent. No further authorization is made than is specifically indicated herein.

Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request.

Witness

Patient, parent, guardian, or legal representative signature

Date