Medical Release Consent

Patient:

Patient Name: _____ DOB: _____

Phone: _____

Requesting from:

Physician:_____ Phone: _____

Location: _____ Fax: _____

Requesting the following:

_____ Baseline Sleep Study with diagnosis of Obstructive Sleep Apnea (G47.33)

_____ Clinical notes related to Sleep Apnea (G47.33), or any sleep related disorder

_____ Other: _____

_____ Other: _____

Recipient:

Apnea & Breathing Clinic
7502 W 80th Avenue, #100
Arvada, CO 80003

Phone: (303) 421-0641
Email: info@ABClinicDenver.com

** PLEASE NOTE:

( ) Patient is in office now.
( ) Patient is scheduled on _____

Fax to: **(303) 421-2179**

I consent release of documents request by □ Dr. Chase Bennett □ Dr. James Bieneman at Apnea& Breathing Clinic of Denver.

_____ _____

Patient Signature Date: