Sleep Associates of Connecticut
the sound sleep center

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REQUEST FOR INFORMATION RELEASE FORM

I hereby authorize _____
Name of Facility or Physician

_____
Address of Facility or Physician

to release information to: _____
Name of Facility or Physician

_____
Location of Facility or Physician

Identifying Information:

Patient's Name: _____

Date of Birth: _____

Date of Treatment: _____

Information Requested: **ALL SLEEP STUDY REPORTS**

Signed:

Patient, Parent, or Legal Guardian: _____

Date: _____