Medical Release Consent:

Patient Name: ____ *DOB:* ______________________

Phone: ____

From:

*Physician:*____ *Phone:* _______________________

Location: ____ *Fax:* ___________________________

Requesting the following :

______ *Diagnostic Sleep Study with diagnosis of Obstructive Sleep Apnea (G47.33)*

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

______ *Other:* ____

Recipient:
Apnea & Breathing Clinic
9474 Kearny Villa Rd. #102
San Diego, CA 92126
Phone: (619) 494-5091
Email: info@ABClinicSD.com

***** Please note Patient is :***

( ) Currently in office
( ) Scheduled _________________

Fax to: ***(619) 881-0408***

I consent release of documents request by Dr. Chase Bennett. At Apnea& Breathing Clinic of San Diego.

____ ______________________________

Patient Signature *Date:*

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