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*

Recipient:

Apnea & Breathing Clinic *Phone: (918) 582-1539*

1616 S. Denver *Email:* info@ABClinicTulsa.com

Tulsa, OK 74119

*** Please note Patient is :***

( ) Currently in office.
( ) Scheduled _____

Fax to: ***(918) 582-3903***

I consent release of documents request by Dr. Terry Bennett at Apnea& Breathing Clinic of Tulsa.

_____ _____

Patient Signature *Date:*