WESTMORELAND SLEEP MEDICINE

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Name:_____ Date of Birth:_____

Please release any and all of my medical records (including any/all imaging scans such as CT scans, X-rays, or MRIs) in my file to/from:

Name:_____

Address:_____

_____

Phone:_____Fax:_____

Patient Signature: _____ Date:_____

Parent/Guardian Signature
(if patient is under 18yrs of age): _____