TMJ THERAPY
& SLEEP CENTER
OF NEVADA

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date:_____

To:_____
Physician's Name

_____
Address

_____
City State Zip

I hereby request that my medical records be released to:

_____
Physician's Name (print)

_____
Address

_____
City State Zip

_____
Patient's Name (print) Birth Date

_____
Address

_____
City State Zip

DOB

Patient's Signature:_____ **Date:**_____