Bay Area Sleep Evaluation Center

ACCREDITED THROUGH THE AMERICAN ACADEMY OF SLEEP MEDICINE
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Authorization to release information

I, _____, herby authorize my referring physician, any previous sleep facilities, family members, relative or friend (as listed below) and Bay Area Sleep Evaluation Center to obtain and release any documents that are needed in correspondence with the procedures performed at this facility. I also understand that a copy of this authorization can be used and will be valid as my original signature.

Name & Relationship_____
Name & Relationship_____

X _____ Date _____