Accredited by the American Academy of Sleep Medicine since 1991.

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BOARD CERTIFIED IN INTERNAL MEDICINE,
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AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I, ______________________________, HEREBY AUTHORIZE

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TO RELEASE MY MEDICAL RECORDS TO DR. RICHARD M. SNOW.

PATIENT NAME ______________________________

LAST FIRST MIDDLE

SOCIAL SECURITY # ______________________________

BY SIGNING BELOW I AUTHORIZE DR. RICHARD M. SNOW AND THE SNOW SLEEP CENTER, P.C. TO HAVE ACCESS TO ALL MY MEDICAL RECORDS. I UNDERSTAND THAT THIS REQUEST WILL REMAIN IN EFFECT UNTIL REVOCKED IN WRITING BY ME.

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SIGNATURE DATE

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SIGNATURE DATE