THE SLEEP CENTER OF NEVADA

5701 WEST CHARLESTON BLVD, SUITE # 105 LAS VEGAS, NEVADA 89146
2920 N. GREEN VALLEY PKWY BLDG 3 SUITE # 313 HENDERSON, NEVADA 89014
5751 S. FORT APACHE, SUITE #110 LAS VEGAS, NEVADA 89014
702-818-2444(w); 702-818-2440(f)

MEDICAL RELEASE FORM

I hereby authorize the release of all my medical information relating to the treatment I have received. Please do not release any further information to any other person(s) without my consent.

RELEASE INFORMATION TO:

Name of Facility:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

PATIENT INFORMATION:

Patient Name:_____

S.S#:_____ D.O.B:_____

I understand that if records are released to me that pursuant to NRS 629.06 I will **be charged a fee of $0.60 per page.**

Signature:_____ Date:_____