Dreamhaven
dental sleep medicine

PATIENT AUTHORIZATION
TO RELEASE CONFIDENTIAL INFORMATION:

IN ACCORDANCE WITH MINNESOTA STATUTES, section 144.355:

I, _____, hereby request and authorize:

_____

to disclose and provide copies of any and all clinical treatment records and information concerning my care, including my most current PSG Report/Sleep Study. Please send this information to:

Dreamhaven Dental Sleep Medicine
13495 Elder Drive, Suite 100
Baxter, MN 56425

Phone: 218-454-0523
Fax: 218-454-0524
Email: frontdesk@greenhavendental.com

Signed: _____ Date: _____