Sleep Study Release

I, the undersigned, grant permission to Dr.
to release information and/ or data of sleep studies conducted from my medical records to:

Keith R. Larson, DMD
Duy Anh Tran, DMD

Sleep Health Now
17895 NW Evergreen Pkwy #130
Beaverton, OR 97006
Office: (503)-713-3209
Fax: (503)-533-4300

Patient Name: _____

Patient Address: _____

Patient Birthdate: _____

Parent (If under 18 yrs): _____

Patient or Guardian Signature: _____

Date: _____