

Steve Marinkovich, D.D.S.
Authorization for Release of Medical Information

I, _____ (Patient's Name)

_____ (Patient's Address)

_____ (Patient's Date of Birth)

Herby authorize:

_____ (Physician's Name)

_____ (Physician's Address)

To release any information in my medical records relating to my diagnosis and treatment history for sleep disorders and sleep disordered breathing to:

Steve Marinkovich
5225 Tacoma Mall Blvd, Suite E-104
Tacoma, WA 98409
Telephone: 253-474-3223
Fax: 253-473-6762

to assist in the evaluation of my suitability for treatment of sleep disordered breathing.

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

Patient's Signature: _____ **Date:** _____