Fax to: _____
Attn:_____

Records Request

Date:_____

I, the patient,_____DOB, _____authorize the
Please print
disclosure of the following medical/dental information, as described below:

____X-rays (Must be sent by mail only)

____Chart Notes

____Reports/Findings

____Sleep Test Results

Requested information can be received by mail, email or fax. See below.

If mailing, please send to:

Northwest Institute of Dental Sleep Medicine
Dr. Donald J. Johnson, D.D.S.
114 W Neider Ave
Coeur d'Alene, ID 83815

~ OR ~

Email: *info@nwsleepdoc.com* ***Fax: 866 488-2537***

Signed:_____Date:_____

Date Requested: _____
Date Received: _____