TMJ & Sleep Therapy Centre
of New Hampshire

Records Release

To better coordinate your treatment, it is required that you list the professionals including all physicians, dentists and therapists, that you have consulted concerning your present symptoms. In addition, please list your general physician and family dentist. Include address whenever possible.

Family Physician: _____ ***Dentist***: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Sleep Physician: _____ ***Sleep Center***: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Physical Therapist: _____ ***Other***: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

I authorize the release of my medical records related to my diagnosis and treatment for obstructive sleep apnea and craniofacial dysfunction to the following office: **TMS & Sleep Therapy Centre of NH @ Meyer Family Dentistry Inc., PO Box 238, W. Nottingham, NH 03291**. Email: info@tmjsleepnewhampshire.com , Phone # 603-942-6021, Fax# 603-942-8047.

I understand that the professionals I have listed above, may be sent information regarding my diagnosis and treatment as well.

Name (printed): _____

Signature: _____ Date: _____