youngdentistry
SMILE CARE

Request for Release of Sleep Study Results

I, ___________________________(print full, legal name), born _________________ (print date of birth) the undersigned, hereby authorize the release of:

- my most recent sleep study results
- any reports, diagnosis or recommendations.

Please forward these records to:

Young Dentistry
324 Guelph St. Unit 8
Georgetown ON
L7G 4B5
T- (905)-873-4800
F - (905) 873-4821
smile@youngdentistry.ca

Signed ____ Date _______________________