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**Medical Records Release**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize you to release medical records to:

Arlington Sleep Medicine, Ltd.  
Deborah Gofreed, MD, Medical Director  
3833 N. Fairfax Drive, Suite 360  
Arlington, VA 22203

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_