

Sleep Solutions of Fredericksburg

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Patient Contacts Authorization

Patient Name: _____

Date: _____

I hereby authorize Sleep Solutions of Fredericksburg to discuss my care and /or appointment reminders with the individual(s) listed below:

Name: _____	Relation: _____
Contact: _____	

Name: _____	Relation: _____
Contact: _____	

Name: _____	Relation: _____
Contact: _____	

Name: _____	Relation: _____
Contact: _____	

Name: _____	Relation: _____
Contact: _____	

Patient's Signature _____

Date: _____