Patient Information Request Form

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

_____

Phone Number: _____ Email Address: _____

Name of Parent or Guardian (If patient is under 18 years old)

_____

Authorization to Release Test Results

I, _____ am requesting a copy of my sleep test results.
Print your name

I hereby authorize Snap Diagnostics to release my results directly to me at

_____.
(Please provide the fax, email or mailing address where you want to receive your results)

Signature: _____ Date of Request: _____