# 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)

_____

Relationship to Patient if Not the Patient _____

**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: _____

*This request is a one-time request and cannot be used as a release form for 3rd party requests for reasons other than the provision of treatment, payment or other standard healthcare operations.*

*This form can be returned to Snap via mail, fax or email. Email is not considered the most secure method of information transfer.*