REM Sleep Center
4211 Medical Parkway
Austin, TX 78756
P: 512.452.0004 F: 512.452.4144

Request for Medical Records

Date: _____

Patient Name: _____ DOB: _____

I am requesting that my sleep study report be sent to the following doctor(s):

_____	_____	_____
Physician Name	Phone Number	Specialty
_____	_____	_____
Physician Name	Phone Number	Specialty
_____	_____	_____
Physician Name	Phone Number	Specialty

as well as my referring physician.

_____ _____
Signature Date

_____
Name (Please Print)