Physician List

Please complete the following information so that we can release medical records to your current physicians. If you do not provide the address and phone numbers, we may be unable to complete the request.

Referring Physician: ❑ **I am a self-referred patient and I have no referring doctor**

Name: _____ Phone # _____

Address: _____
Street City Zip Code

Family Doctor: ❑ **Same as referring physician**

Name: _____ Phone # _____

Address: _____
Street City Zip Code

Any other person or physician who you would like us to send records to:

Name: _____ Phone #_____

Address: _____
Street City Zip Code

If physician, please list specialty: _____

Release of Medical Information

I, _____hereby give *The Sleep Disorders Center of Central Texas* permission to release and/or retrieve my medical records to the above named healthcare professionals as indicated.
(Printed Patient/Guardian Name)

_____ _____
Patient/Guardian Signature Date

**If you would like any of the above persons to stop receiving records from our clinic, you will need to send a written request to: Medical Records, 102 Westlake Drive, Suite 102, Austin, Texas 78746.