

Authorization Letter for Sleep Study

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], hereby authorize [Name of Sleep Center/Doctor] to conduct a sleep study for medical purposes. This evaluation is necessary to assess my sleep patterns and diagnose any potential sleep disorders.

Details of the Patient:

- Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Contact Information: [Your Phone Number, Email Address]

I understand that the results of this study will be shared with my healthcare provider, [Provider's Name], for further evaluation and treatment recommendations.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]