

CENTER FOR NARCOLEPSY RESEARCH
SLEEP RESEARCH CENTER
STANFORD UNIVERSITY MEDICAL CENTER

401 Quarry Road, Suite 3301, Stanford, California 94305 ♦(650)725-6512 ♦Fax (650)725-8910
Emmanuel Mignot, M.D., Ph.D. Director

Date: _____

Sleep Disorders Center

Dear Medical Records Department:

I authorize you to release a copy of my sleep related medical records to:

Center for Narcolepsy
Stanford University Sleep Research Center
701-B Welch Road
Stanford, CA 94304
(Attn: Isabelle Arnulf)

This data is required for a research project on Kleine-Levin Syndrome in which I am participating.

The researchers conducting this study are requesting copies of the results of my *overnight polysomnogram and MSLT, or any sleep related records, including initial evaluations and follow-up visits, EEGs, MRI or TDM reports, biological results.* Please also provide the results of any HLA Blood typing performed.

If you have any questions concerning this request, please contact Isabelle Arnulf (650-724 8839). You may also contact Emmanuel Mignot, MD, PhD, the project manager, at (650) 725-6517.

Sincerely,

Name (Please print)

Signature

Medical Record No. (if known)

Date of Birth

Approximate date of test/s