

SPECIALIST IN PULMONARY CARE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT)

NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

RELEASE MY MEDICAL RECORDS FROM:

RELEASE MY MEDICAL RECORDS TO:

PLEASE RELEASE A COPY OF ALL MY MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO, PROGRESS NOTES, OPERATIVE NOTES, ER NOTES, DISCHARGE SUMMARIES, DISABILITY AND WORKMAN'S COMP, LABORATORY RESULTS AND DIAGNOSTIC TESTS

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

PATIENT: _____ **DATE:** _____