PALMETTO PULMONARY MEDICINE, P.A.

Pulmonary Diseases • Asthma • Critical Care • Sleep Disorders

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Board Certified
Internal Medicine
Pulmonary Disease
Critical Care Medicine
Sleep Medicine

AUTHORIZATON FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print patient's full name) (Birth Date mo/day/yr)

_____ _____
(Street Address) (Social Security #)

_____ _____
(City, State, Zip) (Home Phone #/Cell#)

At the request of the individual, I _____, do hereby authorize _____
(Patient's name) (Name of Facility)

to release: _____*Please include dates or denote All

_____History & Physical _____Progress Notes _____Discharge Summary _____Hospital notes

_____Radiology Reports _____Pulmonary function test _____Pathology Reports _____Operative Notes

_____Lab Reports _____ ECHO _____Sleep Report _____Entire Medical Record

_____Other_____

Information release to: _____
(Name of Company/Agency/Facility/Person)

` _____
(Street Address)

_____
(City, State, Zip)

Phone # _____ Fax # _____
(include area code)

Purpose of Disclosure:

_____Referral to Specialist _____Insurance _____Worker's Compensation _____Change of Doctor

_____Legal Investigation _____Disability Determination _____ Continuing Care _____ Personal

_____Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulation.

_____ _____
Signature of Individual, or Guardian or Personal Representative of patient's estate — Date

_____ _____
Signature of Witness — Date