PREMIER LUNG & SLEEP SPECIALISTS

PULMONICS PLUS

AUTHORIZATION/REQUEST TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

Social Security #: _____ Daytime Phone: _____

❑Release to: OR ❑Obtain from:

Facility Name/Physician/Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request/authorization applied to:

❑Progress Notes ❑Sonograms/X-Ray Reports

❑Operative Report: _____ ❑All Medical Records

❑Lab Results ❑Other: (please specify) _____

Purpose/Reason for this release: _____

I understand that my consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of the previously mentioned, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment. Additionally, I understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient Signature: _____ Date: _____

Signature of Parent/Legal Representative: _____ Date: _____

PHONE 972.923.8923 NEW FAX 877.399.8499

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