SUBURBAN PULMONARY AND SLEEP ASSOCIATIES, LTD.

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Consent for Release of Medical Information

Please **print** clearly and complete in full

Name of Patient ____DOB________________

Address____

City _________________State_________ Phone number___________________________________

Information to be released **FROM:** ______ **Information to be released TO:** __

______________________________________**NAME**____________________________________

______________________________________**ADDRESS**_________________________________

__________________________________**CITY, STATE, ZIP**___________________________________

______________________________________**PHONE**___________________________________

_______________________________________**FAX**____________________________________

Information to be released:

______Complete Records _____Lab Reports ____Sleep Study Reports

______Radiology Reports ______Pulmonary Testing ______Other (specify) _________________

For the following dates: ____

Purpose of Disclosure:

___Permanent transfer ___New Physician ___Dissatisfaction ___New Insurance ___Legal

____Continued medical care ____Other ____

I understand that this authorization includes information regarding mental health, developmental disability, alcohol and/or drug abuse services and HIV test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation. If you DO NOT wish such information to be released, state information to be excluded here: ____.

This authorization expires one (1) year from the date of issue. I also understand that it may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith.

____ Date_________________________

Signature of mark of patient, parent of minor, or legal guardian/estate representative

____ Date_________________________

If patient is unable to sign, the person signing in the authorization will be required to show proof of guardianship, or other authority and relationship to patient allowing him/her to authorized the release of medical information

____ Date_________________________

Witness

No Records will be released without the completion of this form and /or authorization