PULMONARY ASSOCIATES OF SOUTHERN ARIZONA, PC

Please Print

Med. Record No. _____

Name: _____

Birthdate: _____

Phone: _____

I, undersigned, consent to the release of medical information (records)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO/FROM: (circle one)

_____

_____

_____

_____

Primary care provider _____

Information to be released: _____

In addition to the general authorization to release medical records, I further authorize release of the following information if it is contained in my records: **(please initial each line)**

	May be released	May not be released
Drug and alcohol abuse	_____	_____
Mental Health	_____	_____
Diagnosis/treatment of HIV, HIV-related illness, AIDS, AIDS-related illness and communicable disease-related information	_____	_____

DATES OF TREATMENT: _____ to _____

PURPOSE OF DISCLOSURE: _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE after one year (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment information, or records regarding communicable disease-released information, the recipient of this information understands that it is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

_____ _____

Signature of Patient | Signature of Legally Authorized Representative

_____ _____

Date Signed | Date Signed

NOTE: THERE IS A FEE FOR RECORDS RELEASED TO PATIENTS FOR PERSONAL USE.