PULMONARY & SLEEP MEDICINE ASSOCIATES, L.L.P.

PULMONARY DISEASES * SLEEP DISORDERS * CRITICAL CARE MEDICINE * INTERNAL MEDICINE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ SSN: _____

Address: _____ DOB: _____

I hereby authorize the use or disclosure of the individuality identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the release information may not be protected by federal privacy regulations.

Persons/ Organizations providing the information:

_____

_____

_____

Persons / Organization receiving the information:
PULMONARY & SLEEP MEDICINE ASSOC
6572 River Park Drive, Ste101
Riverdale, GA 30274

☐ I would like records faxed to PSMA at 770-997-4790..

☐ I would like records mailed directly to PSMA at the address above.

What to Release- Please choose the records you would like released:

☐ Office Notes ☐ Laboratory Reports ☐ X-ray Reports
☐ Sleep Studies ☐ Respiratory testing ☐ Other (Specify)_____
☐ All Your facility's records ☐ Records from Other Physicians

Please include the following:

☐ HIV Information ☐ Psychiatric Treatment ☐ Drug & Alcohol Abuse Treatment

Purpose- Please indicate the reason of records disclosure:

☐ Continuity of Care ☐ To obtain Disability ☐ Armed Forces Requirements
☐ Use in Lawsuit ☐ Personal Use ☐ Other: _____

I understand that I may revoke this release at any time by submitting a written request. I AUTHORIZE MY RECORDS TO BE FAXED UNLESS OTHERWISE NOTED. This authorization will expire one year from date signed or on ____ / ____/ ____.

I understand that once these records are released, the information is no longer protected by Your facility and may potentially be re-disclosed by PSMA. Your employees and physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name Relationship

***** Note: If facsimile, the information in this is legally privileged and confidential information intended for the recipient only. You are hereby notified that any dissemination, distributing, or copy of this fax is strictly prohibited. If you have received this telecopy in error, please notify us immediately by telephone and return the original message to us via the United State Postal Service. *****

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Riverdale, GA 30274
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Fax (770) 997-4790

1100 Hospital Drive
Stockbridge, GA 30281
(770) 506-0434
Fax (770) 692-2107

132 Old Norton Road,
Ste 101
Fayetteville, GA 30214
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