

SUBURBAN PULMONARY AND SLEEP ASSOCIATIES, LTD.

PULMONARY MEDICINE CRITICAL CARE MEDICINE SLEEP DISORDER MEDICINE

Peter C. Freebeck, MD

Consent for Release of Medical Information

Please print clearly and complete in full

I. (Nikki) Hansra-Godfrey M.D., M.S.

Name of Patient _____ DOB _____

Address _____

Paul J. Jagielo, M.D.

City _____ State _____ Phone number _____

Dr. Usman Khan

Information to be released FROM: _____ Information to be released TO: _____

NAME

ADDRESS

CITY, STATE, ZIP

PHONE

FAX

Arnon E. Rubin, M.D.

Vasantha Samala, M.D.

David C. You, M.D.

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

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