Pulmonary & Sleep Specialists, PC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This document authorizes _____(clinic/office/physician) to

release health information from the records of _____

Date of birth: _____, to _____ at:

Address or Fax: _____

Specify records to be released: office notes _____ Sleep study _____ Lab _____

Radiology _____ other (specify): _____

Patient or Rep Initials

_____ **I understand that information released by this authorization may be disclosed by the recipient to the entitiy/entities indicated above.**

_____ **I understand that I have the right to revoke this authorization, in writing, at any time by sending such written**

notification to the practice at: **Pulmonary & Sleep Specialists, PC Phone: 404 499 0533**
2665 North Decatur Road Fax: 404 499 0531
Suite 230
Decatur, Georgia 30033

_____ **I understand that a revocation is not effective to the extent that my physician may have already disclosed the health information in accordance with previously signed authorizations.**

_____ **I understand that this authorization ends on _____ (1 year unless otherwise stated)**

_____ **I agree to pay a reasonable cost to cover this service. (50 cents per page or $35 for entire medical record, Whichever is less)**

_____ **I place no limitation on release of history of illness or diagnostic and therapeutic information.**

_____/_____
Patient or Legal Representative Signature / Date

Patient Representative:

____ **Parent/Guardian of Minor Patient**

____ **Guardian/Conservator**

____ **Next of Kin/Executor of Deceased**

Pulmonary & Sleep Specialists, PC FAX: 404.499.0531

PSS STAFF: _____ Phone: 404.499.0533

Revised 05/2013
company: forms: authorization for release of health information