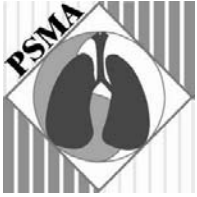


**PULMONARY & SLEEP MEDICINE ASSOCIATES, L.L.P.**  
 PULMONARY DISEASES \* SLEEP DISORDERS \* CRITICAL CARE MEDICINE \* INTERNAL MEDICINE

**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:** **PULMONARY & SLEEP MEDICINE ASSOC**  
 6572 River Park Drive, Ste 101  
 Riverdale, GA 30274

**Persons / Organization receiving the information:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- I would like to pick up records: please call me at \_\_\_\_\_.
- I would like records mailed (please indicate 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 PSMA 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 \_\_\_\_/\_\_\_\_/\_\_\_\_.

Once these records are released, the information is not protected by Pulmonary & Sleep Medicine Associates and may potentially be re-disclosed by the party who received these records. PSMA, its 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. \*\*\*\*

Revised 10.29.13

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