



**PULMONARY MEDICINE, INFECTIOUS DISEASE
AND CRITICAL CARE CONSULTANTS**
MEDICAL GROUP, INC.

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1485 River Park Drive, #200
Sacramento, CA 95815-4501
Telephone: (916) 325-1040
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Business Office
1300 Ethan Way, Suite 600
Sacramento, CA 95825-2296

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

PURPOSE FOR RELEASE (Please Circle):

SELF Follow-up Care Consult/Second Opinion Legal Needs Other: _____

<input type="checkbox"/> PMA to OBTAIN Records From: DOCTOR/FACILITY: _____ _____ ADDRESS: _____ _____ FAX: _____ Please Deliver Records by FAX to 916-669-4100 Or mail to PMA Business Office – Attn: Medical Records 1300 Ethan Way, #600, Sacramento, CA 95825 Please Include this request with records	<input type="checkbox"/> PMA to RELEASE Records to: NAME: _____ _____ ADDRESS: _____ _____ FAX: _____ _____ Disclose to medical providers by FAX/MAIL _____ Deliver Via Mail (Records on CD Only) _____ Pickup @ Business Office: 1300 Ethan Way, #600, Sacramento, CA 95825
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Information from the medical record of the above named patient (Please Initial All Applicable):

_____ All Medical Record Information	_____ Lab, Imaging, and Medical Test Data
_____ All Account Information	_____ Report of Patient’s Condition
_____ Office Notes	_____ Other: _____

Please specify the dates or times period for the information selected above: _____

IF APPLICABLE, specific permission is given to release/obtain information related to (Please Initial):

_____ Drug and/or Alcohol Dependency	_____ Sexually Transmitted Disease
_____ Acquired Immune Deficiency Syndrome (AIDS)	_____ Human Immunodeficiency Virus (HIV)
_____ Psychiatric/Psychological Testing	

This authorization is effective until revoked or terminated by the patient or the patient’s personal representative. You may revoke or terminate this authorization by submitting a written revocation to Pulmonary Medicine Associates. You should contact the PMA Privacy Officer to terminate this authorization. **Fees: For current patients, there is no charge for records being released to another medical doctor. However, there is a \$15.00 fee for disclosing the records to all others as authorized in this request and payment must be received prior to processing.**

SIGNED: _____ DATE: _____

Relationship to Patient: (Please Circle) Self Parent Guardian Conservator