PULMONARY, CRITICAL CARE, ALLERGY, IMMUNOLOGY, INFECTIOUS DISEASE AND SLEEP MEDICINE ASSOCIATES

Leaders in outcomes oriented, evidence based, compassionate, cost effective care

1300 Ethan Way, Suite 600
Sacramento, CA 95825
Telephone: (916) 679-3548

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

PURPOSE FOR RELEASE (Please Circle)**:**
SELF Follow-up Care Consult/Second Opinion Legal Needs Other: _____

☐ PMA to **OBTAIN** Records From:	☐ PMA to **RELEASE** Records to:
DOCTOR/FACILITY:	NAME:
ADDRESS:	ADDRESS:
FAX:	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**	**_____ FAX/MAIL to my medical provider above** **_____ Mail my records to me on a secured CD** **_____ Will pick up printed records at:** **1300 Ethan Way, #600, Sacramento, CA 95825**

Information from the medical record of the above named patient (Please Initial All Applicable):

_____ All Medical Record Information
_____ All Account Information
_____ Office Notes
_____ Lab, Imaging, and Medical Test Data
_____ Report of Patient's Condition
_____ 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
_____ Acquired Immune Deficiency Syndrome (AIDS)
_____ Psychiatric/Psychological Testing
_____ Sexually Transmitted Disease
_____ Human Immunodeficiency Virus (HIV)

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, including release to self, as authorized in this request and payment must be received prior to processing. Printed records are subject to a 10 cents per page print fee.**

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