PULMONARY, CRITICAL CARE, INFECTIOUS DISEASE AND SLEEP MEDICINE ASSOCIATES
Medical Records Department
1300 Ethan Way, Ste. 600
Sacramento, CA 95825
(916) 679-3548 Phone
(916) 483-0814 Fax
www.pmamed.com

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** Patient Records From:	☐ PMA to **RELEASE** Patient Records to:
PROVIDER/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**	_____ **Release to my medical provider listed above** _____ **Mail records to me on a secured CD** _____ **I 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
_____ Billing Information
_____ Specialist Visit Notes
_____ Lab, Imaging and Medical (Diagnostic) Tests
_____ Report of Patient's Condition
_____ Other: _____

***Please specify the dates or time period for the information selected above:** _____
***If no dates are provided we will release last years worth of records.**

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 Medical Records Department to terminate this authorization. **Fees: For current patients, there is no charge for records being released to another medical doctor/facility. However, there is a $15.00 fee for disclosing the records to all others, including self-release, as authorized in this request and payment must be received before processing. Printed records are subject to a 10 cents per page print fee.**

SIGNED: _____ DATE: _____
Relationship to Patient: (Please Circle) Self Parent/Guardian Conservator HealthCare Power of Attorney