



**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) 669-4100 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):

Personal Continuity of Care Insurance Purposes Legal Purposes Other: _____

☐ PMA to OBTAIN Patient Records From: PROVIDER/FACILITY: _____ ADDRESS: _____ FAX: _____	☐ PMA to RELEASE Patient Records to: NAME: _____ ADDRESS: _____ FAX: _____
Release to PULMONARY MEDICINE ASSOCIATES FAX to 916-483-0814 or mail to PMA - Attn: Medical Records 1300 Ethan Way, #600, Sacramento, CA 95825 ***Please include this request with records***	☐ Release directly to the recipient listed above ☐ Mail electronic records to me on a secured CD ☐ Call me to arrange pick up of printed records or to make other release arrangements.

To Include information from the medical record of the above-named patient (Please Initial All Applicable):

_____ Office Visit Notes _____ Pulmonary Function Tests _____ Sleep Study Reports
_____ Other (Please specify): _____

***Enter the date range or time period for the records selected above:** _____

***If no date range is provided, we will release records from the past year.**

Specific permission is given to release/obtain information related to (Please Initial ALL Applicable):

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

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. **If you are not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.** 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