Salem Pulmonary Associates, PC & Sleep Center

AUTHORIZATION TO REQUEST/DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I _____ _____ authorize Salem Pulmonary Associates, P.C. to
(Patient name) *(DOB)*

☐ ***Request From***_____
(Name and address of recipient).

☐ ***Release To***_____
(Name and address of recipient).

A copy of my medical information. The information will be used for the following purpose(s):

_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

__ All hospital records (including nursing records and progress notes)
__ Transcribed hospital reports
__ Medical records needed for continuity of care
__ Most recent five-year history
__ Laboratory reports
__ Pathology reports
__ Diagnostic imaging reports
__ Clinician office chart notes
__ Dental records
__ Physical therapy records
__ Emergency and emergency care records
__ Billing statements
__Other _____

__ Please send the entire medical record (all information) to the above named recipient.

*****Must be initialed to be included in other documents*****

__ *HIV/AIDS-related records __ *Mental health information __ *Genetic testing information
__ **Drug/alcohol diagnosis, treatment or referral information as follows: _____

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

*** Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed*.

__ This authorization is limited to the following treatment: _____
__ This authorization is limited to the following time period: _____
__ This authorization is limited to a workers' compensation claim for injuries from:_____
(Date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____ _____ _____ _____
(Date) *(Signature of patient)* *(DOB)* *(Date)* *(Signature of person authorized by law)*

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