Regional Lung & Sleep Clinic
Art of Healing, Science of Care

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Diplomate, American Boards of
• Internal Medicine
• Pulmonary Medicine
• Sleep Medicine

MEDICAL INFORMATION RELEASE

Encounter Number:		Medical Record Number:
Patient Name:	Social Security Number:	Date of Birth:
Patient Address: City	State	Zip
I authorize:		To release my records to Lung and Sleep Clinic

Name of Doctor/Hospital/Insurance Company/Other Agency:

Attention:

Address and/or Fax #:

For the purpose of: Continuity of Care

Information from within the Hospital records relating to my identity, diagnosis, prognosis or treatment.

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below as exceptions. I also understand, that my record may contain:

- AIDS/HIV related information, if AIDS?HIV related tests were ordered by physician; "Confidentiality of HIV related information act, PA Law Act 148.
- Mental Health Information, if mental health treatment was given by physician; PA Mental Health Procedure Act.
- Drug or Alcohol information, if drug or alcohol tests were ordered or treatment provided by physician. Drug & Alcohol Abuse Control Act 42 CFR, Part 2.

Date(s) of Service: ______ The information to be released is:

☐ Anesthesia Records	☐ Consultation Report	☐ D/C Planning
☐ Discharge Summary	☐ EKG, EEG, Stress, ECHO	☐ Emergency Dept. Records
☐ Facesheet/Demographics Sheet	☐ Films	☐ History and Physical
☐ Laboratory Results	☐ Onsite Review	☐ Pathology Report
☐ Psychiatric Evaluation	☐ Trauma Records	☐ Vascular Studies
☐ Verbal Information	☐ X-ray Report	☐ Other (Please Specify)

☐ EXCEPTION: I do not give permission to release (Please Specify): ______

- I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that my protected health information may be disclosed by the provider for patient care purposes.
- I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in order to effectuate the purpose for which it is given unless revoked by me.
- I understand that my authorization will remain effective for a period of 90 days from the data of my request.

______ Patient Signature/Date

______ Witness to Signature/Date

______ Signature of Authorized Person/Date

______ Witness to Signature/Date

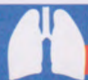
Relationship: ______

Patient: ☐ Received ☐ Refused a copy of this form

☐ Unable to sign because: ______

Information Released to: ______

Date: ______



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