Authorization to Release Medical Records

Carolina Pulmonary & Sleep Clinic PLLC
570 New Waverly Place, Suite 140, Cary, NC 27518
Phone:(919) 439 8580 Fax (919) 463 5600
www.carypulmonary.com

_____ _____
Last Name, First , Middle Date of Birth (month / day /year)

_____ _____
Street address Last four of Social Security Number

_____ _____
City State Zip Code Home phone number

I, _____, do hereby authorize the release of the following medical records:

- o All Records
- o Sleep Study (s)
- o PFT
- o CXR /CT Chest
- o Lab Reports
- o History & Physical
- o Progress Notes
- o Discharge Summary
- o ER Records
- o Other:

TO:	FROM:
Carolina Pulmonary & Sleep Clinic 570 New Waverly Place, Suite 140 Cary, NC 27518 **Fax (919) 463 5600** Tel (919) 439 8580 www.carysleep.com	_____ Name of Facility _____ Street Address - City, State Zip **Fax*:** _____ Phone: _____

* Our office prefers that Medical Records be sent via fax to the intended recipient. Therefore, to quicken the delivery process, we would greatly appreciate your effort to verify and provide the correct fax number.

Purpose of Disclosure:

- o Referral to Specialist
- o Insurance
- o Workers Comp
- o Change of Doctor
- o Legal Investigation
- o Disability determination
- o Self records
- o Continuing Care
- o Other (please specify): _____

I hereby authorize Carolina Pulmonary & Sleep Clinic to disclose health information of the above named patient to the entity mentioned in this form. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

(Please check one) _____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychiatric Care and/or Psychological Assessment, and Treatment for Alcohol and/or Drug Abuse.

_____ _____
Signature of individual or guardian or personal representative of patient's estate Date