SIGN-OFF

* PLEASE READ CAREFULLY *

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IMPORTANT

This printing order will not be processed until proof has been checked, signed and returned to our office WITH PROOF COPY.

☐ OK to PRINT

☐ Show Revised proof

Signed: _____ Date: _____

Authorization for Release and Disclosure of Protected Health Information

Pulmonary Consultants & Primary Care Physicians Medical Group, Inc.

❑ 1310 W. Stewart Dr.
Suite 408
Orange, CA 92868
Ph. 714-639-9401
Fax 714-919-8800

❑ 1010 W. La Veta Ave.
Suite 750
Orange, CA 92868
Ph. 714-361-6600
Fax 714-919-8804

Patient Name_____S.S. # _____

DOB_____Day Phone #_____Evening Phone #_____

Address _____

City_____State_____Zip _____

I understand that my records are protected under state and federal confidentiality laws and cannot be disclosed without my written consent except in specific instances described by law. I hereby authorize the release and exchange of medical information as follows. Please read and complete **each** item or the release may be delayed.

Please **OBTAIN** information **FROM** the following:	Pending Appointment Date:_____ Please **SEND** my Medical Information **TO**:
_____ *Name of Physician/Clinic/Hospital*	_____ *Name of Person/Facility to Receive Information*
_____ *Address*	_____ *Address*
_____ *City, State, Zip*	_____ *City, State, Zip*
_____ *Phone*	_____ *Phone*
_____ *Fax*	_____ *Fax*

Information to be released:

❑ Progress Notes ❑ Radiology Reports ❑ Radiology Films ❑ Lab Results

❑ Special Reports/Dates_____ ❑ Immunizations

❑ EKG ❑ PFT ❑ Other (specify)_____

Continued on back

Special Note: I understand that the information disclosed may contain matter that is protected by federal and state laws, including information which may relate to ALCOHOL, DRUG AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASE.

I specifically consent to release and disclosure of this information._____*Please initial*

Purpose of Disclosure: (Check all that apply)
❑ Complete Transfer of Care ❑ Second Opinion ❑ Attorney *(Reason)*_____
❑ Insurance Change ❑ Insurance Application/Benefits/Claim ❑ Other_____

This consent is good for 90 days. For a smaller episode of time, please specify date. _____

*Signature*_____*Date* _____

Parent or Legal Guardian Signature, if applicable _____

FOR OFFICE USE ONLY - ROUTE IMMEDIATELY TO MEDICAL RECORDS DESK

_____ _____
Staff Member Receiving Request/Dept. ***Date***