221 W. Colorado Blvd, Suite 525 Dallas TX 75208
Phone/Fax: 214-960-5681

MEDICAL RELEASE FORM

Patient Name: ____

Date of Birth: ____________________________ SSN: ______________________________

I hereby authorize:

Dallas Pulmonary & Critical Care P.A.
221 W. Colorado Blvd. PV 2 Suite 525
Dallas, TX 75208
Phone/Fax: 214-960-5681

_____To obtain medical records from

_____ To release medical records to

Physician's Name: ____

Street Address: ____

Phone #: ____________________________ Fax #: ______________________________

The following information that is being requested is:

_____ Entire Record _____ PFT/Spiro _____CT/CXR/PET _____PSG/CPAP titration

Other: ____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information may include, but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV & AIDS. I understand that I have the right to refuse or to withdraw this authorization. I also understand that this authorization will remain in effect for 180 days unless I specify an earlier date here_________.

Patient Signature: __________________________________Date: ________________________

Print Name: ____