Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680
Phone (770) 586-0300, Fax (770) 586-0311

Authorization to Disclose / Transfer Health Information

I, the signed patient or legal guardian of patient authorize

_____
(Name of Physician, Medical Practice, or Treating Hospital)

_____
(Address of Facility) (City) (State) (Zip)

_____
(Telephone #) (Fax # - Very Important)

To release medical / health information listed below from the records of:

_____
(Name of Patient) (Date of Birth)

For the following services:

☐ Medical Summary
☐ Major Diagnostic Procedures (Ct-scan, Stress Test, EGD, Colonoscopy….)
☐ Recent Lab Results
☐ Entire Medical Record
☐ Hospitalization / Date _____
☐ Other _____
☐ Other_____

• I acknowledge that the medical information released may include all treatments of physical and mental illnesses, drug/alcohol abuse, and past medical history.
• I know I am fully responsible for the fees, if any, brought by this request.
• I understand that my authorization will expire within one year from today and that I may revoke this authorization earlier in writing (this revocation will not apply to information that has already been released.)
• I understand that this consent has no bearing on the ability of this office, and its right to consent a claim with my insurance.

I authorize the information to be disclosed to and used by:

Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680
Phone# (770) 586-0300 Fax :(770) 586-0311

_____
Signature of Patient or Guardian Date of Birth Social Security Number

_____ _____
Print Patient Name Date Date