

Pulmonary & Sleep Associates
515 SW Horne, Suite 200
Topeka, KS 66606
785-234-5480

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL
INFORMATION

Date

Patient Name

Date of Birth

Address

City, State, Zip

I, _____, hereby authorize _____ to disclose confidential information from the above named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of _____. I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information, and that this information is subject to redisclosure by the recipient, and will no longer be protected.

Please send the requested information to:

Please send the following:

Name

Address

City, State, Zip

Fax

Signature of Patient or Legal Guardian

Relationship