Patient Name: _____ **Phone #:** _____

DOB: _____ **SS#:** _____

I HEREBY AUTHORIZE: (CHECK APPROPRIATE CHOICE)

COLLIN COUNTY PULMONARY ASSOCIATES
6100 Windcom Court, Suite 102
Plano, Texas 75093
972-596-8928 Fax
972-964-0170 Phone

TO RELEASE MY MEDICAL RECORDS TO:

_____
DOCTOR OR CLINIC

_____
ADDRESS

_____
CITY **STATE** **ZIP**

_____
FAX # **PHONE #**

PLEASE FAX AND/OR MAIL THE FOLLOWING TO THE ABOVE NAMED:

☐ **ENTIRE MEDICAL RECORDS** (including ALL records received from all other sources)

I understand that the information in these records may not be further disclosed to anyone else without another signed authorization from me or unless such disclosure is specifically required or permitted by law.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken on this authorization. Unless revoked earlier, this authorization will expire ninety (90) days from date of my signature.

Patient Signature: _____ Date: _____

If signed by representative, state relationship: _____

Witness Signature: _____ Date: _____

Office use only

Records request received _____ by _____

Logician updated with request on _____ by _____

Records mailed _____ Logician updated by _____