Patient Name: _____ Phone #: _____

DOB: _____ SS#: _____

I HEREBY AUTHORIZE: (CHECK APPROPRIATE CHOICE)

Collin County Pulmonary Associates
1101 Raintree Circle, Suite 100
Allen, Texas 75013
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 _____