PULMONOLOGY ASSOCIATES, INC.

Breathe easier. Live better.

Authorization to Release Medical Records

Patient Name:

_____

Date of Birth:

_____

I authorize Pulmonology Associates to obtain medical records from:

_____

_____

_____

_____

I authorize Pulmonology Associates to release my medical records to:

_____

_____

_____

_____

Records to release/obtain:

☐ Entire Medical Record

☐ Labs

☐ Radiology Reports (CT Chest, Chest X-ray, etc.)

☐ PFT/Spirometry

☐ Last OV note including H&P and Medication List

100 E. Lancaster Avenue | Lankenau MOB West Suite 230 | Wynnewood, PA 19096

phone: 610.642.3796 | fax: 610.642.2943

Patient’s Signature:

_____

Date:

_____

_____

100 E. Lancaster Avenue | Lankenau MOB West Suite 230 | Wynnewood, PA 19096

phone: 610.642.3796 | fax: 610.642.2943