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

Main Line Health Center | 1991 Sproul Road | Broomall, PA 19008

phone: 484.476.3649 | fax: 610.325.1399

Patient's Signature:

_____

Date:

_____

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