Pulmonary and Sleep Center of New England

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Authorization for use or Disclosure of Medical Record Information

PATIENT INFORMATION

Patient Name: ____ Date of Birth: _______________

Patient Address: ____ Home Phone: _______________

City: ______________________ State: ______ Zip: ______________ Cell Phone: _________________

RELEASE INFORMATION TO

I hereby authorize Pulmonary and Sleep Center of New England to: ○ **Release To:** ○ **Obtain From:**

☐ Mail Copies To: ☐ Hold for Patient Pick-up ☐ Discuss Medical Information With:

Name/Facility: ____

Address: ____ Phone: ____________________

City: ______________________ State: ______ Zip: ______________ Fax: ______________________

PURPOSE OF REQUEST: ○ Personal ○ Continuing Care ○ Insurance ○ Legal ○ Other
○ Transfer out of Practice / Reason? ______________________________

INFORMATION TO BE RELEASED

☐ 2 year abstract (includes 5 years of diagnostics)
☐ Test results (sleep study, PFT)
☐ Radiology results
☐ Office Notes
☐ Other (Specify):____

Note: You will be invoiced at the allowable RI Statute rate. RI Statute Copy Fee: $15.00 clerical fee, plus $.76 per page for the first 50 pages.

THIS AUTHORIZATION IS VALID FOR ONE YEAR UNLESS YOU SPECIFY OTHERWISE. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME.

____ ________________
Patient Signature Date

____ ________________
Legally Recognized Representative Signature Date

____ ________________
Signature of Witness Date