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/OBTAIN INFORMATION TO/FROM

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

☐ Fax copies To: ☐ Hold for Patient Pick-up ☐ Discuss Medical Information With:

Physician 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/OBTAINED

☐ 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 $.75 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

____ ______________
Name of Staff Taking Medical Request Date
Patient picked up the following: VISIT NOTES / PFT / HST / PSG / CPAP / DME

____ ______________
Name of Staff Processing Medical Request Date