PA FORM #E
Created 12.31.2015
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Authorization to Receive/Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to request/Release information regarding your care from the entity listed below. Please review, complete, sign & date and return to our front desk.

Patient Name: _____ Date Of Birth: _____ SSN #:_____

I, _____, authorize Pulmonary Associates, PA to communicate with the entity listed below regarding my care and treatment.

1. _____ _____
Name **Address**

Telephone #: (_____) _____ _____**85**_____

Fax#: **(_____)** _____ **City/State** **Zip Code**

❑Most Recent Lab Results **❑Last 3 Office Notes**

❑CXR/PET Report **❑CT Thorax/Chest** **❑ PFT/Spirometry**

❑ ALL Sleep Study Data **❑ Other (Please Specify):**_____

PLEASE FAX/SEND RECORDS TO:

☐ 9225 N. 3rd Street
Suite #205
Phoenix, AZ 85020
Phone: 602.258.4951
FAX: 602.395.8984

☐ 5750 W. Thunderbird Road
Bldg. E Suite #500
Glendale, AZ 85306
Phone: 602.258.4951
FAX: 602.862.1131

☐ 10585 N. Tatum Blvd
Suite #D130
Paradise Valley, AZ 85253
Phone: 602.258.4951
FAX: 602.602.395.8984

☐ 1112 E. McDowell Road
Phoenix, AZ 85006
Phone: 602.258.4951
FAX: 602.340.1853

☐ 5151 E. Broadway Road
Suite #107
Mesa, AZ 85206
Phone: 480.258.4951
FAX: 480.325.3461

☐ 19841 N. 27th Ave
Suite #102
Phoenix, AZ 85027
Phone: 480.258.4951
FAX: 623.434.8310

"BACK-UP" FAX LINE: _____

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other Information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECEIPIENT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

_____ _____

Patient/Parent/Guardian Signature **Form to EXPIRE 1 year from original signed date**