PULMONARY ASSOCIATES

5151 E. Broadway Rd.
Suite 107
Mesa, AZ 85206
P: 480-290-7000

3811 E. Bell Rd.
Suite 107
Phoenix, AZ 85032
P: 602-340-1689

19841 N. 27th Avenue
Suite 102
Phoenix, AZ 85027
P: 602-443-4068

5750 W. Thunderbird Rd.
Bldg. E-500
Glendale, AZ 85306
P: 602-298-1932

PA FORM #D
Revised 01/26/2021

# Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.
(Ex: prescription pick-up, appointment coordination, record retrieval, etc…)

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

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

1. _____ _____
**Name** **Address**
Telephone #: (_____) _____ _____**85**_____
**City/State** **Zip Code**

2. _____ _____
**Name** **Address**
Telephone #: (_____) _____ _____ **85**_____
**City/State** **Zip Code**

___ Verbal Communication

___ Other (Please Specify): _____

**The purpose of this release:** COORDINATION OF CARE

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**