Georgetown Pulmonary Associates, PA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

Patient Name: _____ DOB: _____

I, _____, hereby authorize Georgetown Pulmonary to disclose confidential information from the above named patient's medical records as specified below.

I understand that this authorization is valid for this request only, and that only office notes and results that have been ordered by the physicians of Georgetown Pulmonary Associates, PA will be provided via paper copy unless requested otherwise.

Please specify which documents you wish to receive:

☐ PFT reports

☐ Labs

☐ Radiology (CXR, CT, etc.)

☐ Office Notes

☐ Medication List

☐ Six Minute Walk Results

☐ Other Testing (please specify) _____

Please send the requested information to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship