Pulmonary Associates of St. Augustine, P.A.

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Medical Information Release Authorization

Patients' full legal name:____

Date of birth :_________________ Social security Number :__________________

Address: ____

Telephone :____

Release my information to/from:

Providers' Name:____

Providers' Address:____

Providers' Fax:______________________ Telephone:________________________

The purpose of the requested disclosure is: _________________________________

The information to be used for disclosure includes the following (please check) :

___ Progress notes   ___ Hospital records   ___ Consultation reports

___ Laboratory results   ___ Radiology reports   ___ Cardio-Pulmonary

___ Substance abuse (alcohol/ drugs)   ___ Mental health/Psych history

___ HIV / AIDS related info   ___ Other_____________________________