Pulmonary & Sleep Specialists, PC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name (please print clearly): _____

Birthdate: _____

This document authorizes Pulmonary & Sleep Specialists, PC to release my health information as indicated:

___ All records January 01, 2022 – present

___ All archived records

Select One:

____ **Send me a FREE PDF of my records via secure HIPPA email.**

My email address is (please print clearly): _____

In making this request, I agree with the following:

*I understand that information released by this authorization may be disclosed by the recipient

*I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification

VIA E-MAIL to INFO@PSSATL.COM

VIA Mail to: Pulmonary & Sleep Specialists, PC
PO Box 500038
Atlanta, Georgia 31150

*I understand that a revocation is not effective to the extent that my physician may have already disclosed the health information in accordance with previously signed authorizations.

*I understand that this authorization ends on _____ (1 year unless otherwise stated)

*I agree to pay a reasonable cost to cover this service.

*I place no limitation on release of history of illness or diagnostic and therapeutic information

X_____/ x_____

Patient or Legal Representative Signature **Date**

___ Legal Patient Representative (indicate relationship: _____)

____ Parent/Guardian of Minor Patient

____ Guardian/Conservator

____ Next of Kin/Executor of Deceased