PULMONARY ASSOCIATES

1750 EL CAMINO REAL, STE. 307
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
PLEASE FILL OUT FORM COMPLETELY OR IT IS NOT VALID

As required by the Health Information Portability and Accountability Act of 1196 (HIPAA) and California law, our practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practice without authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid of not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

1. Reason for Request: (Circle One)

Changing to another Doctor / Transferring care
Disability Claim
Continued care (e.g. specialist)
Personal copy (prepaid charge will apply)
Other _____

2. Patient Information:

Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____

3. Medical Records: (Circle One) ( ) To ( ) From

Bernard J. Steyer, MD
Lawrence A. Coskey, MD
Robert M. Jasmer, MD
Charles K. Everett, MD
Lisa L. Chen, NP

Alexander D.Zider, MD
Siyuan A.Ni, MD
Elliot L.Naidus, MD
Neha Agarwal, MD

4. Medical Records: (Check One) ( ) To ( ) From

Please send via ( ) Mail ( ) Fax _____

Name: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

5. Information to be released

Your records will be forwarded as requested. Please indicate if there are specific dates of service you wish to be sent. If this section is left blank or is unspecific, we will send current pertinent medical records which may include only records from this office. Please note that "All Records" will **NOT** be considered specific.

Dates of Treatment _____ **Reason for Release** _____

Please send by_____ **Appointment Date**_____

6. Protected Information

If your record contains protected health information and you **DO** want this information released you **MUST** initial and check in the appropriate space provided next to each choice.

__HIV related information ___Mental Health related information __Drug and Alcohol related information

7. Signature

I understand that this authorization is subject to revocation at any time.
I understand that a photocopy or facsimile of this authorization will be considered as valid as the original.
I understand that this authorization will expire 90 days from the date of signature and is only valid if it is filled out completely.
I will be fully responsible for any delay caused by failure to complete this form accurately and entirely.
I understand that a copy of the requested records will be sent to the destination I have specified.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I AUTHORIZE THE RELEASE OF RECORDS FOR THE PURPOSE STATED ABOVE.

_____ _____
Signature, Patient or Legal Representative Date

_____ _____
Signature, Parent or Guardian if patient under 18 Date