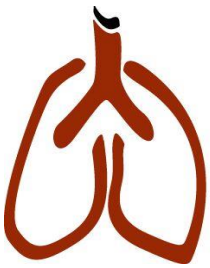

PULMONARY & SLEEP SPECIALISTS

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Client's Name: _____ **DOB:** _____

Florida law requires that information in medical records be held in strict confidence and not be released without your written authorizations. The authorizations you sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of your authorization upon your request.

I, _____ authorize _____
(Name of patient/legal representative) (Agency/Individual in possession of record)
to release (**initial,** by the following, any or all that apply):

_____ A. The general medical record created at the medical facility
_____ B. The following information from the medical or case management record:
_____
_____ C. Records obtain from the following providers:
_____
_____ D. STD Records
_____ E. TB Records
_____ F. HIV/AIDS Records
_____ G. Drug/Alcohol treatment records
_____ H. Psychiatric/Psychological information
_____ I. Adult and child abuse information

For the purpose of: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Witness: _____ _____
(Legal guardian's relationship to patient)

Dr.Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

_____