PULMONARY ASSOCIATES / PENINSULA SLEEP CENTER
1720 EL CAMINO REAL, STE. 150
BURLINGAME, CA 94010
P. #650-697-5367 F. #650-697-3843

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
PLEASE FILL OUT FORM COMPLETELY OR IT IS NOT VALID

1. Reason for Request: (Check 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.Transfer Records: (Check One) ( ) To ( ) From

___ Donald Ho, MD ___ Bernard J. Steyer, MD ___ Deepti Sinha, MD, FRACP
___ Lawrence A. Coskey, MD ___ Charles K. Everett, MD, MAS
___ Robert M. Jasmer, MD ___ Mehran Farid-Moayer, MD, FAASM

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

Physician's Name: _____

Physician's 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

For additional/personal copies - <u>ATTACH $15 PAYMENT (You may be billed additional if the quantity of records copied exceeds the standard fee).</u>

1. **<u>Check the box</u>** for preferred delivery and make sure the information is both **<u>accurate</u>** and **<u>complete.</u>**
2. Provide **<u>payment with request.</u>** Requests for additional copies will not be processed without the $15 payment.
3. **Please leave this section blank if you do not wish to obtain additional copies.**

U.S. Mail: _____ E-Mail: _____

Street: _____Fax:_____

City: _____ State: _____Zip:_____