

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES

A PROFESSIONAL LLP

| Patient Name: | | Date of Birth: | | |
|--|--|--|--|--|
| Previous Name: | Treating Physician: | | | |
| Deleges To | | | | |
| Release To: | | | | |
| | | | | |
| City: | | | 7in: | |
| Phone: | 50 | .ate | Zip: Email: | |
| | | | | |
| · · · · · · | _ | | the organization, agency or individual may include information regarding the | |
| ☐ Drug/alcohol abuse | e STD/AIDS/HIV | Psycholo | ogical/psychiatric conditions | |
| | INFORMATION TO | BE DISCLOSED | | |
| My health information limited | to the date(s): | | hy fav | |
| Other (specify): | | | | |
| payment or enrollment). | _ | | to get health care benefits (treatment, | |
| actions already taken by the revoke this authorization i | ne above-named practice f its purpose was to obta | based upon the in insurance. | is below. If I do, it will not affect any is authorization. I may not be able to | |
| Once the office discloses h Privacy laws no longer pro | | erson or organiz | ation that receives it may re-disclose in | |
| Patient or legally authorized individual signa | iture | Date | Time | |
| Printed name, if signed on behalf of the pati | ient | Relationship to patient (parent, legal guardian etc) | | |