CARDIO-PULMONARY ASSOCIATES
MEDICAL GROUP
Serving the Monterey Peninsula since 1979

30 GARDEN COURT MONTEREY, CA 93940 ◆ PHONE: (831) 646-8570 FAX: (831) 646-5435

AUTHORIZATION FOR RELEASE OF INFORMATION

To ensure your request is handled promptly and accurately payment must be made at the time of your request. Please allow 15 days for your records to be processed.

In order to protect your privacy, ID will be required at the time of pick up.

Please indicate the following: ☐ Mail records ☐ Pick-up records

PATIENT NAME: DATE OF BIRTH:

I hereby authorize Cardio-Pulmonary Associates, Medical Group Inc. to:

☐ Obtain information from:

☐ Release information from my medical record or Send any obtained information to:

NAME: ______________________________________ PHONE/FAX: ____________________________

ADDRESS: ________________ CITY: ___________________ STATE: ___________ ZIP: __________

The following information may be released: ☐ Entire Record ☐ Typed Reports ☐ Lab ☐ Other, Including:

For the following dates of service: From___________________through___________________

The purpose of this release is: ☐ Changing Physicians ☐ Legal ☐ At Patient's Request ☐ Other Purpose:

PLEASE READ THE FOLLOWING AND INITIAL BEFORE SIGNING THIS FORM.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one year from the date of signing. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment and health operations purposes. However, the Practice is not required to agree to a patient's request for restrictions.

I recognize that the information may contain drug/alcohol information that is protected by federal and state law. I do ________, do not ________ specifically consent to disclosure of such information.

I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV/AIDS testing information. I do ________, do not ________ specifically consent to disclosure of such information.

Cardio-Pulmonary Associates Medical Group, Inc. will charge an administrative fee of $10.00 plus $.25 per page Test Lab CD's will be processed for $10.00. Mailed records will be charged an estimated postage costs.

________________________________ ___________________ ____________________________
Signature of Patient Date Witness

I understand I may receive a copy of this by signing.