PULMONARY MEDICINE, INFECTIOUS DISEASE
AND CRITICAL CARE CONSULTANTS
MEDICAL GROUP, INC.

Five Medical Plaza, #190	6403 Coyle Ave #450	1485 River Park Drive, #200	Business Office
Roseville, CA 95661-3037	Carmichael, CA 95608-6335	Sacramento, CA 95815-4501	1300 Ethan Way, Suite 600
Telephone: (916) 786-7498	Telephone: (916) 482-7621	Telephone: (916) 325-1040	Sacramento, CA 95825-2296
Fax:(916) 786-2715	**Fax: (916) 972-7734**	**Fax: (916) 669-4100**	

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________________ **Date of Birth:** ____________________

Address: ______________________________________ **SSN:** ____________________

PURPOSE FOR RELEASE (Please Circle)**:**
SELF Follow-up Care Consult/Second Opinion Legal Needs Other: ____________________

☐ PMA to **OBTAIN** Records From:	☐ PMA to **RELEASE** Records to:
DOCTOR/FACILITY:	NAME:
ADDRESS:	ADDRESS:
FAX:	FAX:
Please Deliver Records by FAX to 916-669-4100 **Or mail to PMA Business Office – Attn: Medical Records** **1300 Ethan Way, #600, Sacramento, CA 95825** **Please Include this request with records**	_____ **Disclose to medical providers by FAX/MAIL** _____ **Deliver Via Mail (Records on CD Only)** _____ **Pickup @ Business Office:** **1300 Ethan Way, #600, Sacramento, CA 95825**

Information from the medical record of the above named patient (Please Initial All Applicable):

______ All Medical Record Information ______ Lab, Imaging, and Medical Test Data
______ All Account Information ______ Report of Patient's Condition
______ Office Notes ______ Other: ____________________

Please specify the dates or times period for the information selected above: ____________________

IF APPLICABLE, specific permission is given to release/obtain information related to (Please Initial):

_______ Drug and/or Alcohol Dependency _______ Sexually Transmitted Disease
_______ Acquired Immune Deficiency Syndrome (AIDS) _______ Human Immunodeficiency Virus (HIV)
_______ Psychiatric/Psychological Testing

This authorization is effective until revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Pulmonary Medicine Associates. You should contact the PMA Privacy Officer to terminate this authorization. **Fees: For current patients, there is no charge for records being released to another medical doctor. However, there is a $15.00 fee for disclosing the records to all others as authorized in this request and payment must be received prior to processing.**

SIGNED: ______________________________ DATE: ________________
Relationship to Patient: (Please Circle) Self Parent Guardian Conservator