Emerald Coast Pulmonology, PA
John J. Koszuta MD, FCCP
c/o 1049 John Sims Parkway- Suite 2
PMB #248
Niceville, Florida 32578
Ecp1@nym.hush.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____
request and authorize Emerald Coast Pulmonology, PA, to furnish copies, or information from medical records to:

_____
(Name of Person(s)/Agency)

I fully understand the original records are the property of this practice and are to be used for the following purpose:

Continuity of Care

_____
Signature of Patient Date Soc. Sec No. (last 4 digits only) Date of Birth

_____
Person authorized to sign for patient Relationship to Patient

_____
Signature of Witness Date

This authorization expires six months from date of signature.