Authorization to Release Medical Records

I hereby authorize WhiteBridge Pulmonary Care to release and/or obtain medical records regarding my treatment, incl

Name of Entity/Individual: _____

Phone Number: _____

Address: _____

City/State/Zip: _____

This authorization is valid for one year from the date signed and may be revoked at any time by providing written notic

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____