PULMONARY & SLEEP CONSULTANTS, LLC

M. Qadoom, M.D.

Board Certified:
Pulmonary Medicine
Critical Care Medicine
Sleep Medicine

PULMONARY & SLEEP CONSULTANTS, LLC

WESTERVILLE SLEEP DIAGNOSTIC SERVICES

MEDICAL INFORMATION RELEASE FORM -- HIPAA RELEASE FORM

I hereby authorize the use and disclosure of any and all medical records, including but not limited to records of any substance abuse, psychiatric/mental health information and/or HIVAIDS information of (name of patient and/or person authorized to release information) to/from Pulmonary and Sleep Consultants:

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Professional/Organization authorized to **send/receive this information** (all information must be completed):

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number/FAX: _____

For the purpose of:

_____	Continuity of Care	_____	Transferring to Another Provider for My Care
_____	Insurance Billing	_____	Other (please specify)
_____	Legal Reasons		_____

I understand that if there is a fee for sending the records that I am requesting, the office will contact me and payment in full will be required prior to sending records.

This release of information authorization will remain in effect for one year following the date on the form.

Print Patient Name: _____ Date: _____

Signature: _____

If someone other than the patient is making this request, please specify name, relationship, and reason for the request: _____