AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____
Patient's Name

_____
Date of Birth

_____
Address

_____
City State Zip code

I, _____, hereby authorize _____ to disclose confidential information from the above named patient's medical records, including laboratory results, radiology testing results, medications, hospitalization information, office notes, and treatment plan to Pulmonary & Sleep Consultants, LLC

I understand that this authorization will expire in 180 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information, and this information is subject to redisclosure by the recipient, and will no longer be protected.

Please send requested information to:

Pulmonary & Sleep Consultants, LLC
4512 Kirkwood Highway, Suite 300-B
Wilmington, DE 19808
Fax: 302-994-4080

_____
Signature of Patient or Legal Guardian

_____ Date: _____
Relationship