WEST COAST PULMONARY & SLEEP DISORDERS CENTER

AUTHORIZATION FOR THE USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________

Provider to release my health information:

- ☐ Rajan Bhatia, MD
- ☐ Darren Maehara, MD
- ☐ G. Sofia Nelson, MD
- ☐ Aswin Nukala, MD
- ☐ Andrew Weymer, MD
- ☐ Laura Craver, PA-C

Telephone Number: _____________ Fax Number: ____________

I voluntarily authorize and direct the health care provider(s) selected above to release/disclose my health information in her or her possession as listed below. A photocopy of this authorization shall be as valid as the original.

PHI to be released	To Whom
☐ Recent History & Physical/Office Notes	
☐ Lab Reports	
☐ X-ray Reports	
☐ Operative Reports	
☐ Discharge Summary	
☐ Pathology Reports	
☐ Pulmonary Function Tests	
☐ Sleep Studies	
☐ All pertinent records to patient care	
☐ Other:	

____ ________________

Signature of Patient or authorized representative Date