Pulmonary & Critical Care Associates

Authorization for General Medical Records Release to Pulmonary & Critical Care Associates

PATIENT INFORMATION (Please print)	
Name:	**Date of Birth:**
Address:	**City, State, Zip:**
Last four SSN:	**Phone Number:**

By my signature below, I authorize the custodian of my medical records:

_____ Provider/Entity Name

_____ Provider/Entity Address

_____ Provider/Entity Phone/Fax

To disclose/release the following information (check all that apply):

- ☐ All records Billing Records
- ☐ Office notes (previous 2 years)
- ☐ Laboratory/pathology records (previous 3 years)
- ☐ Radiology records (previous 3 years)
- ☐
- ☐ Pharmacy/prescription records
- ☐ Sleep studies/Titration Reports
- ☐ Other:_____

Please send the records listed above to the following Pulmonary & Critical Care Associates, PC address:

☐ **Shelby Township Office**
50505 Schoenherr Road, Suite 290
Shelby Township, MI 48315
Phone: 586-314-0080 / Fax: 586-731-6257

☐ **St. Clair Shores Office**
21000 Twelve Mile Road, Suite 112
St. Clair Shores, MI 48081
Phone: 586-772-5550 / Fax: 586-772-2470

☐ **Roseville Office**
25689 Kelly Road, Suite 100
Roseville, MI 48066
Phone: 586-445-5995 / Fax: 586-585-1281

This authorization shall not be valid for greater than one year from date of signature.
I understand that PCCA will not condition any aspect of my treatment on whether I sign this authorization.
I have the right to revoke this authorization, except to the extent of the custodian of records and/or Pulmonary & Critical Care Associates, P.C., has relied on it, by sending a written request to: *Practice Manager – 50505 Schoenherr Road, Suite 290, Shelby Township, MI 48315.*

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient/patient representative Representative's authority to sign (i.e. parent, guardian, POA, executor, etc.)