MID-ATLANTIC PULMONARY CLINIC
MARIA L. JISON, MD, LLC
PHONE 888-340-3330 FAX 240-489-6262

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____

Mid-Atlantic Pulmonary Clinic is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: _____

For the Purpose of : _____
(optional)

_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

Information Requested:

- o H & P
- o Discharge Summary
- o Clinic Notes
- o Lab Test Results
- o Radiology Results
- o EKG/Echo Report
- o PFT Results
- o Operative/Pathology Reports
- o Other

I release Mid-Atlantic Pulmonary Clinic/Maria L. Jison, MD, LLC, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Mid-Atlantic Pulmonary Clinic, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date