AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's Name				Date of Birth
	Last	First	M	I
Address				Phone
I hereby authorize:				
		Sydney C. Cl	piratory Associates noslovsky, M.D.	
		Sudha Kar 65 Nortl San Jose (408)279-14	roblewski, M.D. rupaiah, M.D. n 14 th Street , CA 95112 00 Telephone 216 Facsimile	
	Release To		Ol	otain From
		Person / Organizatio	n to receive information	1
Street Address			Fax Number	er
City, State, and Zip	•		Telephone	Number
Information to be	released:			
Office I	Notes	from	to	
Laborat	tory Reports	from	to	
Imaging	g/X-Ray Reports	from	to	
Other		Specify		
understand that me Sexually Transmitt information. This	edical records released ted Diseases, alcohol of authorization is is spec	may contain protecte or drug use, or mental cific for this request o	d health information (P health service, and here nly and is valid for one	ecords and any administrative charges. I HI) related to Hepatitis, HIV status, eby authorize the release of this year from the date of this authorization ction has already been taken.
Signature of Patier	nt			Date