AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's Name_____Date of Birth_____
Last First MI

Address_____Phone_____

I hereby authorize:

South Bay Respiratory Associates
Sydney C. Choslovsky, M.D.
Donald A. Wroblewski, M.D.
Sudha Karupaiah, M.D.
65 North 14th Street
San Jose, CA 95112
(408)279-1400 Telephone
(408)279-3216 Facsimile

Release To ____ Obtain From ____

The above patient is requesting the following information be made available to or from:

_____
Person / Organization to receive information

_____ _____
Street Address Fax Number

_____ _____
City, State, and Zip Code Telephone Number

_____

Information to be released:

Office Notes	from _____	to _____
Laboratory Reports	from _____	to _____
Imaging/X-Ray Reports	from _____	to _____
Other	_____ Specify	

I understand that California law allows us to charge a fee for duplication of medical records and any administrative charges. I understand that medical records released may contain protected health information (PHI) related to Hepatitis, HIV status, Sexually Transmitted Diseases, alcohol or drug use, or mental health service, and hereby authorize the release of this information. This authorization is is specific for this request only and is valid for one year from the date of this authorization release date. I may withdraw this authorization at any time except to the extent that action has already been taken.

_____ _____
Signature of Patient Date