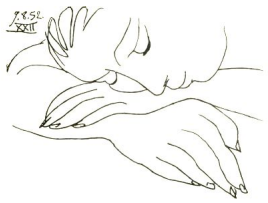
Pulmonary and Sleep Associates of Marin



100 Rowland Way, Suite 300
Novato, CA 94945

Phone: 415-878-0225
Fax: 415-878-0215
MarinPulmonarySleep.com

REQUEST FOR TRANSFER OF HEALTH INFORMATION
FOR MEDICAL TREATMENT

I HEREBY REQUEST THE TRANSFER OF HEALTH INFORMATION FOR:

Name of Patient: _____ Date of Birth: _____
LAST FIRST

Other Names Used: _____ Telephone #: _____

I AUTHORIZE:

_____
(Name of Facility Records are Requested FROM)

Address:_____

Telephone #: _____ Fax #:_____

TO DISCLOSE TO:

Pulmonary and Sleep Associates of Marin
100 Rowland Way, Suite 300
Novato, CA 94945
Tel: 415-878-0225 Fax: 415-878-0215

RECORDS TO BE TRANSFERED:

☐ All the records or

☐ The portion of the records concerning:

☐ Procedure Reports ☐ Laboratory Tests ☐ Consultation Reports ☐ Progress Notes

☐ History & Physical ☐ Discharge Summary ☐ Radiology Reports ☐ Billing Reports

☐ Other: _____

Date(s): _____

SIGNATURE: _____ **Date:** _____

Print Name:_____ Telephone: _____

If you are signing as a representative of the patient, please provide your name and your relationship to the patient:

_____ _____

Name Relationship

EXPIRATION: This authorization will automatically expire one year from the date of execution unless a different end date is specified: _____

The purpose of this transfer of health information is for medical treatment