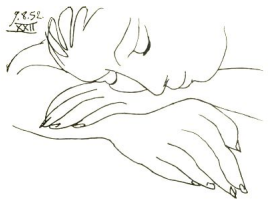
*Pulmonary and Sleep Associates of Marin*



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