Florida Lung & Sleep Apnea Center, LLC
Breathe Well • Sleep Well • Live Well
Pulmonary Physicians of South Florida, LLC

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AUTHORIZATION FOR RELEASE OF RECORDS

TODAY'S DATE: Month (Mes) ____ Day (Día) ____ Year (Año) ____

PATIENT'S NAME:

First Name (Primer Nombre) ____ Middle Name (Segundo) ____ Last Name (Apellido) ____

DATE OF BIRTH: Month (Mes) ____ Day (Día) ____ Year (Año) ____

I ____, HEREBY AUTHORIZE

____

TO RELEASE ALL OF MY RECORDS, WHICH INCLUDES HIV, MEDICAL HEALTH STATEMENTS, INITIAL EVALUATION NOTE, LAST FOLLOW-UP NOTE, PFT RESULTS, PATHOLOGY REPORTS AND, RADIOLOGY TESTS TO:

Florida Lung And Sleep Apnea Center, LLC / Pulmonary Physicians of South Florida, LLC
12600 Pembroke Rd., Suite 200 Miramar, FL 33027
Tel: 954-271-0411 Fax: 954-901-2727
Email: Info@FLSAC.com www.FLSAC.com

____ ____

Signature (Firma): Patient / Legal Guardian (Paciente / Representante Autorizado)

Signature (Firma): Witness (Testigo)

____ ____

Printed Name (Letra de Molde) Patient / Legal Guardian (Paciente / Representante Legal)

Printed Name (Letra de Molde) Witness (Testigo)

Date (Fecha): Month ____ Day ____ Year ____

Relationship to Patient (Relación con el Paciente):

☐ Self (Yo) ☐ Legal Guardian (Representante Autorizado) ☐ Other (Otro) ____