Pulmonary
Associates of
Fredericksburg

HIPAA Release Form

I authorize Pulmonary Associates to discuss the following items with the individuals listed below:

Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

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Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

[ ] I do **not** authorize my medical information to be discussed with any party outside of continuity of care with another medical professional.

This authorization will be in effect for one year from the date signed.

Signature _____ Date _____